QUINNIPIAC HEALTH LAW JOURNAL

Volume 19 2017 Number 3

The Quinnipiac Health Law Journal is published twice a year. Articles within issues can be based on academic works produced by students of Quinnipiac University School of Law and/or scholars in the Health Law profession.

The annual subscription rate for individuals is $25 per volume or $13 for a single issue.

The annual subscription rate for institutions with more than five attorneys or professors employed full-time is $35 per volume or $18 for a single issue.

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Volume 19
Number 3
2017

QHLJ

Table of Contents

Notes

SPECIAL CONSIDERATIONS FOR STUDENT SERVICE MEMBERS/VETERANS: A REVIEW OF THE LITERATURE

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Abstract

The number of Operation Iraqi Freedom and Operation Enduring Freedom veterans and service members attending college in recent years has exceeded 500,000. An estimated 20% of these service members/veterans struggle with mental illness, most commonly posttraumatic stress disorder, depression, traumatic brain injury, and substance use. These mental illnesses, as well as several other psychological factors, contribute to making the transition to college life more difficult than for the general population. Furthermore, being a part of military culture leads to a sense of isolation from civilian peers. Without adequate support, student service members/veterans are at risk for poorer academic performance and satisfaction with their educational experience. This paper reviews the current literature pertaining to the health and academic performance of student service members/veterans and makes suggestions for providing on-campus services to this specific population.

INTRODUCTION

Post-9/11 GI Bill History and Utilization

In June 2008, the U.S. government signed into law the Post-9/11 Veterans Educational Assistance Act.[1] The bill created a robust educational benefits program for service members who have served on active duty for 90 days or more since September 10, 2001.[2] Since the benefits are tiered based on the number of days on active duty, it also gives current and previously activated National Guard and Reserve members the same benefits as active duty service members as of December 2010.[3] Educational benefits include up to 100% of tuition

[1] Lauren Kirkwood, *More Veterans Taking Advantage of Post-9/11 GI Bill*, MCCLATCHYDC (Mar. 17, 2014), http://www.mcclatchydc.com/2014/03/17/221479/more-veterans-taking-advantage.html.

[2] *Id.*

[3] LESLEY MCBAIN ET AL., FROM SOLDIER TO STUDENT II: ASSESSING CAMPUS PROGRAMS FOR VETERANS AND SERVICE MEMBERS, AM. COUNSEL ON ED. 5 (July 2012),

and fee coverage, a monthly housing stipend, up to $1000 per year for books and supplies, a one-time relocation allowance, and the ability to transfer benefits to family members.[4] Between 2009, when the GI Bill was enacted, and 2012, the number of veterans, service members, and family members utilizing their benefits rose from 564,487 to 945,052.[5]

Mental Illness Prevalence among Veterans

A unique trend among veterans of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), compared to previous wars in which the Unites States military was involved, is the disproportionate prevalence of psychological and cognitive pathology relative to the physical injuries typically associated with combat.[6] Furthermore, those that are wounded are now much more likely to survive the injury.[7] This trend is so profound that, between 2000 and 2012, mental disorders were the leading cause of hospitalization for active duty service-members, accounting for 192,317 hospitalizations.[8] Based on their review of recent literature, Shiner and colleagues estimated that, of the 1.25 million OIF/OEF service members eligible for Veterans Health Administration (VHA) services, 16.6 percent of them have post-traumatic stress disorder (PTSD).[9] Tanielian and Jaycox also reported that approximately one third of returning veterans are currently affected by PTSD or depression, or report enduring a possible traumatic brain injury (TBI) while deployed.[10] For this reason, PTSD and TBIs have been dubbed the "signature injuries" of the Iraq War.[11]

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http://www.acenet.edu/news-room/Documents/From-Soldier-to-Student-II-Assessing-Campus-Programs.pdf.

[4] *Post-9/11 GI Bill Overview*, MILITARY.COM, http://www.military.com/education/gi-bill/new-post-911-gi-bill-overview.html#tf (last visited Dec. 1, 2016).

[5] Kirkwood, *supra* note 1.

[6] Terri Tanielian & Lisa H. Jaycox, (eds)., *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*, Rand (2008)(See Preface, page iii).

[7] Hannah Fischer, *A Guide to U.S. Military Casualty Statistics: Operation Inherent Resolve, Operation New Dawn, Operation Iraqi Freedom, and Operation Enduring Freedom*, CONGRESSIONAL RESEARCH SERVICE (2014). (Refer to Table 1).

[8] Francis L. O'Donnell (ed.), *Mental Disorders and Mental Health Problems, Active Component, U.S. Armed Forces, 2000- 2011*, 17 ARMED FORCES HEALTH SURVEILLANCE CTR MSMR 1, 11 (2012).

[9] Brian Shiner et al., *Access to VA Sevices for Returning Veterans with PTSD*, 177 MIL. MED. 814, 815 (2012).

[10] Tanielian & Jaycox, *supra* note 6, at xxi. (See page xxi, second paragraph).

[11] Francis L. O'Donnell (ed.), *Signature Scars of the Long War*, 20 ARMED FORCES HEALTH SURVEILLANCE CTR MSMR 1, 2 (2013).

Among those veterans utilizing the Post-9/11 GI Bill, prevalence of mental illness is approximately 20 percent.[12]

Cost of Illness

The cost of these mental illnesses is substantial. In 2008, the RAND Corporation released a report on the "Invisible Wounds of War." According to their data on OIF/OEF veterans, two-year costs associated with PTSD are between $6,000 and $10,000 per person, depending on whether the cost of suicide is included.[13] For major depression, these costs are roughly $15,000 to $26,000, and for co-morbid PTSD and major depression, they are approximately $12,000 to $17,000.[14] One-year costs for service members who have received a diagnosis of TBI are even higher, ranging between $27,000 and $33,000 for mild cases, and roughly $270,000 to $408,000 for moderate or severe cases.[15] However, these estimates neglect costs stemming from substance abuse, domestic violence, homelessness, and several other factors, therefore understating the real costs of deployment-related cognitive and emotional pathology.[16] Of the total costs, approximately 55 to 95 percent can be attributed to reduced productivity.[17] For mild TBI, productivity losses may account for 47 to 57 percent of total costs.[18] On the other hand, mortality accounts for 70 to 80 percent of costs for moderate to severe TBI.[19]

For these reasons, there have been a handful of studies published in recent years which attempt to identify difficulties faced by student service members/veterans [SSM/V] related to their unique experiences and common medical and mental health comorbidities. This paper will attempt to summarize the available data and provide recommendations for how to best treat SSM/V suffering from mental illness or struggling

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[12] Craig J. Bryan & AnnaBelle O. Bryan, *Sociodemographic Correlates of Suicidal Thoughts and Behaviors Among College Student Service Members/Veterans*, 63 J AM. COLL. HEALTH 502, # (2015).

[13] Tanielian & Jaycox, *supra* note 6, at 200.

[14] *Id.*

[15] *Id.* at 214-15. ("Annual costs associated with traumatic brain injury are even higher, ranging from $25,571 to $30,730 per case for mild cases in 2005 (or $27,259 to $32,759 at 2007 price levels) and from $252,251 to $383,221 for moderate/severe cases in 2005 ($268,903 to $408,519 at 2007 price levels)).

[16] *Id.* at 215.

[17] *Id.*

[18] *Id.*

[19] *Id.*

to adjust to life at an academic institution.

PSYCHIATRIC MORBIDITY

Depression and Suicide

Major Depressive Disorder [MDD] is characterized by episodic depressed or irritable mood associated with diminished interest or pleasure in most, if not all, activities.[20] During these episodes, individuals typically experience decreased appetite, difficulty falling or staying asleep, low energy, and problems concentrating or making decisions.[21] They will often describe feeling worthless, helpless, hopeless, or excessively guilty.[22] At times, their anguish becomes so unbearable that they feel their only means of escaping it is to end their own life.[23] These episodes last, at minimum, 2 weeks, but often persist for several months.[24] However, 20 percent of depressed individuals will need a year or more to begin to experience resolution of their symptoms.[25]

The societal impact of Major Depressive Disorder in recent years has been massive. It is the fourth leading cause of disability worldwide according to the World Health Organization.[26] In the United States, an estimated 16 million adults (6.9%) suffered from at least one major depressive episode in the last year.[27] Suicide was listed as the tenth

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[20] AM. PSYCHIATRIC ASSOC., DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, FIFTH EDITION (2013). (Section II: Diagnostic Criteria and Codes under Depressive Disorders. Criteria include "depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful); and markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).").

[21] *Id.* ("Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (Note: In children, consider failure to make expected weight gain.) Insomnia or hypersomnia nearly every day. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down). Fatigue or loss of energy nearly every day.)").

[22] *Id.* ("Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).").

[23] *Id.* ("Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.").

[24] *Id.*

[25] William Coryell et al., *The Time Course of Nonchronic Major Depressive Disorder: Uniformity Across Episodes and Samples,* 51 ARCH. GEN. PSYCHIATRY, 405, # (1994).

[26] Ronald C. Kessler, *The Costs of Depression*, 35 PSYCHIATR CLIN. NORTH AM. 1, # (2012).

[27] SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, RESULTS

leading cause of death overall and the second leading cause of death among adults aged 25-34.[28] In 2013, a national survey from the Association for University and College Counseling Center Directors indicated that rates of anxiety (46.2%), depression (39.3%), and suicidal ideation (17.9%) continued to be even higher among college students than among the general population.[29] Furthermore, one-quarter of them were taking psychotropic medications.[30] Likewise, among student service members/veterans, Rudd, Goulding, and Bryan found 34.6% endorsed experiencing "severe anxiety" and 23.7% endorsed "severe depression."[31]

Rates of suicidal ideation among this SSM/V cohort were profound, with 46% indicating they had any suicidal thoughts at some point in the past, 20% endorsed suicidal thoughts with a plan, 10.4% endorsed thinking of suicide "often or very often," and 7.7% endorsed having a previous suicide attempt.[32] Even more concerning was 3.8% of the sample reported the odds they would attempt suicide in the future was "likely or very likely."[33] These responses are significantly worse than those in the most recent American College Health Association data, with 7.4% of the general student population endorsing "seriously considering suicide" and 1.5% reporting a suicide attempt.[34] Holland, Malott, and Currier identified "meaning made of stress" as one psychological risk factor of suicide and life-threatening behavior among student service members/veterans.[35] They particularly

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FROM THE 2012 NATIONAL SURVEY ON DRUG USE AND HEALTH: MENTAL HEALTH FINDINGS 14 (2013) (*see* Figure 2.3).

[28] National Vital Statistics System: National Center for Health Statistics, CDC, *10 Leading Causes of Death by Age Group, United States – 2014,* http://www.cdc.gov/injury/images/lccharts/leading_causes_of_death_age_group_2014_1050w760h.gif (last visited Feb. 15, 2016).

[29] DAVID R. REETZ ET AL., ASSOCIATION FOR UNIVERSITY AND COLLEGE COUNSELING CENTER DIRECTORS ANNUAL SURVEY, REPORTING PERIOD: SEPTEMBER 1, 2012 THROUGH AUGUST 31, 2013, AUCCCD 12 (2013), http://files.cmcglobal.com/AUCCCD_Monograph_Public_2013.pdf.

[30] *Id.*

[31] M. David Rudd et al., *Student Veterans: A National Survey Exploring Psychological Symptoms and Suicide Risk*, 42 PROFESSIONAL PSYCH.: RESEARCH & PRACTICE 354, 357-58 (2011).

[32] *Id.* at 358.

[33] *Id.*

[34] *Reference Group Executive Summary*, ACHA-NCHA II, 14 (Spring 2013)..

[35] Jason M. Holland et al., *Meaning Made of Stress Among Veterans Transitioning to College: Examining Unique Associations with Suicide Risk and Life-Threatening Behavior*, 44 SUICIDE LIFE THREAT. BEHAV. 218, 218 (2014). ("Meaning made of stress has been shown to be a unique predictor of mental and physical health. In this study, we examined the unique

noted that those with superior ability to comprehend or make sense of life stressors scored lower on the Suicidal Behaviors Questionnaire-Revised.[36]

Apart from its impact on physical health, depression also appears to have a negative impact on academic success.[37] Although the exact nature of this association is difficult to ascertain, it is reasonable to assume that symptoms such as decreased energy and motivation, difficulty concentrating, and low self-worth do not facilitate excelling in an often rigorous and competitive academic environment.[38] This hypothesis is supported by research from Heiligenstein and Guenther, who found that students endorsing moderate to severe depressive symptoms also described missing classes, decreased academic performance, and (increased?) interpersonal problems at school.[39] Another study found that students diagnosed with depression had, on average, a GPA 0.49 points lower than the general student body.[40] Fortunately, treatment had a protective effect of about 0.44 grade points.[41]

Post Traumatic Stress Disorder

By the very nature of their position as a soldier, veterans are frequently exposed to injury and death inflicted by one human onto another. These brutal, frightening experiences very frequently have long-lasting psychological and physiological consequences.[42] Constant awareness of one's environment, as well as a heightened sensitivity to any changes in it, may be adaptive for survival when one could be

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associations between two facets of meaning made of stress (comprehensibility and footing in the world) and suicide risk and life-threatening behavior among military veterans who have transitioned to college were examined, controlling for demographic factors, religiousness, combat-related physical injury, combat exposure, depressive symptoms, and posttraumatic stress symptoms. Findings suggest that comprehensibility (having "made sense" of a stressor) is uniquely associated with lower suicide risk and a lower likelihood of driving under the influence of drugs or alcohol and engaging in self-mutilating behaviors.")

[36] *Id*. at 12.

[37] Eric Heiligenstein & Greta Guenther, *Depression and Academic Impairment in College Students*, 45, J OF AM. COLL HEALTH, 59 (1996); Alketa Hysenbegasi et al., *The Impact of Depression on the Academic Productivity of University Students*, 8, J. OF MENTAL HEALTH POL'Y & ECON., 145, # (2005).

[38] *See supra* note 37, sources cited therein.

[39] *Id.*

[40] Hysenbegasi, *supra* note 37.

[41] *Id.*

[42] JUDITH HERMAN, TRAUMA AND RECOVERY: THE AFTERMATH OF VIOLENCE - FROM DOMESTIC ABUSE TO POLITICAL TERROR, BASIC BOOKS 20-3, 1997.

attacked at any moment.[43] Furthermore, increased heart and respiratory rate, dilated pupils, and diversion of energy and oxygen supplies from digestive organs and the cerebral cortex to large limb muscles all improve one's ability to fight or flee when a true threat appears.[44] However, when this state of hyperarousal persists in the context of safety, it is highly indicative of Post Traumatic Stress Disorder.[45]

The lifetime history of PTSD in general college student populations has been estimated to be between 4-8%.[46] There are a number of studies showing that Post Traumatic Stress Disorder is associated with a variety of high-risk health behaviors, particularly substance abuse.[47] Widome and colleagues also found that OEF/OIF students who had been given a diagnosis of PTSD within the last year had a 3-fold greater risk for fighting.[48] Related research examining the relationship between PTSD, alcohol, and aggression in Vietnam-era veterans showed that only hyperarousal symptoms, specifically, were positively correlated with aggression (directly and indirectly through alcohol abuse).[49]

Another analysis of a sample of OEF/OIF veterans who have accessed VA healthcare services showed that those with PTSD were more likely to use tobacco.[50] Since there is evidence for a bi-directional causal relationship between tobacco use and PTSD, it is plausible that PTSD may be a mediating factor in the high rates of tobacco use

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[43] *Id.* at 34-5.

[44] *Id.*

[45] AM. PSYCHIATRIC ASSOC., *supra* note 20. ("Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following: Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects. Reckless or self-destructive behavior. Hypervigilance. Exaggerated startle response. Problems with concentration. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).").

[46] Brian Borsari et al., *Posttraumatic Stress Disorder and Substance Use Disorders in College Students*, 22 J. OF COLL. STUDENT PSYCHOTHERAPY, 61 1, 17 (2008).

[47] Rachel Widome et al., *Post-Traumatic Stress Disorder and Health Risk Behaviors Among Afghanistan and Iraq War Veterans Attending College*, 35 AM. J HEALTH BEHAV., 387 1,2 (2011).

[48] *Id.* at 4.

[49] Casey T. Taft et al., *Posttraumatic Stress Disorder Symptoms, Physiological Reactivity, Alcohol Problems, and Aggression Among Military Veterans*, 116 J. ABNORM. PSYCH., 498, 503 (2007).

[50] Beth E. Cohen et al., *Association of Cardiovascular Risk Factors with Mental Health Diagnoses in Iraq and Afghanistan War Veterans Using VA Health Care*, 302 JAMA 489, 491 (2009).

among the OEF/OIF population.[51]

Unfortunately, of the estimated 207,610 OEF/OIF veterans who suffer from PTSD, only 58% of them utilized services through the VA to obtain treatment.[52] On the other hand, this rate is significantly higher than the National Comorbidity Study Replication (NCSR) found in the general community.[53] According to NCSR's results, only 7.1% of adults spoke to a healthcare provider about PTSD symptoms in the year following onset, and just over 50% did so in their lifetime.[54]

Traumatic Brain Injury

As mentioned above, along with PTSD, traumatic brain injuries [TBI] are considered the "signature injuries" of OEF/OIF.[55] It is estimated that 1 in 6 veterans who participated in these missions sustained a TBI during their time serving.[56] The symptoms of TBI are largely neuropsychiatric in nature.[57] The immediate signs are alterations or loss of consciousness, as well as post traumatic amnesia.[58] During the next few weeks to months after experiencing a TBI, individuals often report varying severities of disturbed sleep-wake cycle, impaired memory and concentration, disinhibition, aggression and lability, apathy, or other changes in personality.[59] For many, these symptoms can last longer than six months and cause significant impairment in daily activities, such as driving, managing finances, and cooking.[60] One study also found, more specifically, a positive correlation between (TBI and experiencing) impairment in fine motor

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[51] Steven S. Fu et al., *Post-Traumatic Stress Disorder and Smoking: A Systematic Review*, 9 NICOTINE TOB. RES 1071, 1082 (2007); A.C. Kirby et al., *Smoking in Help-Seeking Veterans with PTSD Returning from Afghanistan and Iraq*, 33 ADDICT BEHAV. 1448, 1451-52 (2008).

[52] Brian Shiner et al., *Access to VA Services for Returning Veterans with PTSD*, 177 MIL MED 814, # (2012).

[53] Philip S. Wang et al., *Failure and Delay in Initial Treatment Contact After First Onset of Mental Disorders in the National Comorbidity Survey Replication*, 62 ARCH GEN PSYCHIATRY 603, # (2005).

[54] *Id.*

[55] O'Donnell, *supra* note 11.

[56] Charles W. Hoge et al., *Mild Traumatic Brain Injury in U.S. Soldiers Returning from Iraq*, 358 N. ENG. J. MED. 453, 462 (2008).

[57] *Id.*

[58] *Id.*

[59] *Id.*

[60] Amanda R. Rabinowitz & Harvey S. Levin, *Cognitive Sequelae of Traumatic Brain Injury*, 37 PSYCHIATRIC CLINICS OF N. AM. 1, 3 (2014).

skills, executive function, processing speed, and various measures of functional status, including involvement with school or employment.[61] It is also common for individuals to develop mood disorders after sustaining TBI.[62] This is significant as some studies show that comorbid PTSD and depression mediates the relationship between mild TBI and physical and psychosocial symptoms.[63] While those with mild TBI may completely recover in weeks or months, in more severe cases, recovery occurs relatively quickly during the first twelve months with more gradual improvements during the following years.[64]

Substance Abuse

College students are known to be a particularly high risk group for substance abuse.[65] Results from the 2013 National Survey on Drug Use and Health found that among full-time college students aged 18 to 22, 59.4% percent were current drinkers, 39.0 percent were binge drinkers, and 12.7 percent were heavy drinkers.[66] Among those not enrolled full-time in college, these rates were 50.6, 33.4, and 9.3 percent, respectively.[67] As far as illicit drugs, 22.3 percent of full-time college students (aged 18-22) used illicit drugs in the last month, compared to 9.4 percent of the general population ages 12 and older.[68] However, being a college student was negatively associated with tobacco use, as the rate of past month cigarette smoking among full-time college students aged 18 to 22 was found to be 21 percent compared to 34.4 percent among age-matched peers.[69]

Among college students, being an OEF/OIF veteran is further associated with tobacco use, alcohol abuse, and unsafe behaviors

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[61] Mark L. Ettenhofer et al., *Correlates of Functional Status Among OEF/OIF Veterans with a History of Traumatic Brain Injury*, 177, MIL. MED, 1272, 1272 (2012).

[62] Ricardo E. Jorge & David B. Arciniegas, *Mood disorders After TBI*, 37 PSYCHIATRY CLINICS N. AM. 13, # (2014).

[63] Hoge et al., *supra* note 56; Robert H. Pietrzak et al., *Posttraumatic Stress Disorder Mediates the Relationship Between Mild Traumatic Brain Injury and Health and Psychosocial Functioning in Veterans of Operations Enduring Freedom and Iraqi Freedom* 197, J. NERV. MENT DIS. 748, # (2009).

[64] Ettenhofer et al., *supra* note 61.

[65] RESULTS FROM THE 2013 NATIONAL SURVEY ON DRUG USE AND HEALTH: SUMMARY OF NATIONAL FINDINGS, SAMHSA 40 (2014).

[66] *Id.*

[67] *Id.*

[68] *Id.* at 27.

[69] *Id.* at 53.

compared to non-veteran students.[70] Specifically, this latter study found that 48.3 percent of OEF/OIF veteran college students reported high-risk drinking compared to 29.8 percent in the non-veteran students, after adjusting for age, gender, year in school, and race/ethnicity.[71] As mentioned above, this risk increases even further when the student service member carries a diagnosis of PTSD or Major Depressive Disorder.[72] Another study found that the youngest OEF/OIF veterans (< age 25) had higher rates substance use disorders (as well as PTSD) than older OEF/OIF veterans (< age 40).[73]

Violence and Aggression

In addition to the high prevalence of PTSD, depression, and traumatic brain injury, veterans exposed to violent combat are at increased risk of aggressive behaviors upon returning home.[74] Killgore and colleagues found that greater exposure to violent combat, killing another person, and exposure to high levels of human trauma were predictive of risk-related behavior, such as increased quantity and frequency of alcohol consumption as well as verbal and physical aggression toward others.[75] Frequently, the final consequence of their behavior is incarceration, as evidenced by the Bureau of Justice Statistics' 2004 report that 10% of all state prisoners are veterans,[76] and their more recent report that an estimated 703,000 veterans were under correctional supervision in 2007.[77] Their data were consistent with that of Killgore, in that veteran prisoners were more likely to have substance abuse problems, more likely to have committed violent crimes, and twice as likely to have symptoms of mental illness

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[70] Widome et al., *supra* note 47.

[71] *Id.*

[72] *Id.*

[73] Karen H. Seal et al., *Trends and Risk Factors for Mental Health Diagnoses Among Iraq and Afghanistan Veterans Using Department of Veterans Affairs Health Care, 2002-2008*, 99 AM. J. PUB. HEALTH 1651, 1651 (2009).

[74] William D.S. Killgore et al., *Post-Combat Invincibility: Violent Combat Experiences are Associated With Increased Risk-Taking Propensity Following Deployment*, 42 J. PSYCHIATRY RES., 1112, 1112 (2008).

[75] *Id.* at 1116.

[76] MARGARET E. NOONAN & CHRISTOPHER J. MUMOLA, VETERANS IN STATE AND FEDERAL PRISON, 2004, U.S. DEPT. OF JUSTICE, OFFICE OF JUSTICE PROGRAMS (2007) http://www.bjs.gov/content/pub/pdf/vsfp04.pdf.

[77] Christopher J. Mumola & Margaret E. Noonan, *Justice-Involved Veterans: National Estimates and Research Resources*, VHA NATIONAL VETERANS JUSTICE OUTREACH PLANNING CONFERENCE (2008).

compared to non-veterans.[78]

Unfortunately, it is not uncommon for veterans' aggressive behavior to be directed toward one's intimate partner.[79] In 2013, the Department of Defense's Family Advocacy Program received over 18,000 reports of spouse or intimate partner abuse.[80] Symptoms of PTSD, depression, and substance abuse seem to have a role in intimate partner violence [IPV].[81] In one study, one-third of veterans with PTSD reportedly committed acts of domestic violence, particularly those who experienced symptoms of hyperarousal and feelings of helplessness.[82] Another study found that over 80% of veterans with depression committed at least one violent act in the last year, and over 40% committed a severe act of violence, such as choking a partner.[83] In a sample consisting of student service members/veterans, Klaw and colleagues found IPV was correlated with psychological distress, alcohol abuse, anger, hypermasculinity, and endorsing degrading attitudes about women that justify violence toward them.[84] Their data also suggests that individuals may be more likely to act aggressively, rather than use verbal negotiation tactics, when they have high levels of distress and anger and low levels of social support.[85]

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[78] *Id.*; Killgore et al., *supra* note 74.

[79] U.S. DEPT. OF DEF., DEPARTMENT OF DEFENSE FAMILY ADVOCACY PROGRAM CHILD ABUSE/NEGLECT AND DOMESTIC ABUSE DATA TRENDS FROM FY01 TO FY13 (2014), http://www.ncdsv.org/images/DoD_ChildAbuseAndDomesticAbuseDataTrendsFY2001-2013_5-20-2014.pdf.

[80] *Id.* Reporting in FY 13, 17,295 cases of spouse abuse and 996 cases of intimate partner abuse.

[81] Casey T. Taft et al., *Posttraumatic Stress Disorder Symptoms, Physiological Reactivity, Alcohol Problems, and Aggression Among Military Veterans*, 116 J. ABNORM PSYCH., 498, 505 (2007). (See Table 1, "The hyperarousal cluster evidenced a stronger positive association with general aggression at the bivariate level when compared with reexperiencing and avoidance/numbing and when the PTSD symptom clusters were considered together at the multivariate level").

[82] *Id.*

[83] Michelle D. Sherman et al., *Domestic Violence in Veterans with Posttraumatic Stress Disorder who Seek Couples Therapy,* 32 J. OF MARITAL & FAM. THERAPY 479, 484 (2006). (See Table 2).

[84] Elena L. Klaw et al., *Predicting Risk Factors for Intimate Partner Violence Among post-9/11 College Student Veterans*, 31, J INTERPERS VIOLENCE 572, 581 (2014).

[85] *Id.*

THE EFFECTS OF SOCIAL SUPPORT ON MENTAL HEALTH AND ACADEMIC PERFORMANCE

Developing Social Support

Human beings, by nature, are social animals who provide each other support in the form of material goods, protection from threats, and emotional bonding. Over the course of an individual's life, the source of this support is dynamic. Early on, we are primarily supported by our parents or other immediate family members. As we grow older, particularly in late adolescence and early adulthood, relationships with friends and acquaintances become more prominent, in part as a result of increased time spent in environments where we are exposed to peers. However, theorists, such as Erik Erikson, also wrote about developmental changes that promote relational intimacy in the form of romantic interest and more mature friendships.[86] As Whiteman and colleagues point out, "the rates of change in social support are not equivalent across providers."[87] For most, social support from one's family tends to be more stable, while support from peers is more variable.[88] Eventually, as we continue to age, the size of our social support networks shrink, but the quality does not necessarily change.[89]

Beyond age, there are other characteristics that may predict the nature of an individual's social support. For example, there appear to be gender differences in the size of social networks, number of companions, and the support one seeks and receives from relationships.[90] Overall, these data show that women are more likely than men to seek, receive, and provide social support, particularly emotional support.[91] Furthermore, married individuals tend to perceive that they receive higher levels of social support, which is not

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[86] ERIK ERIKSON, IDENTITY: YOUTH AND CRISIS, INTERNATIONAL UNIVERSITIES PRESS (1968).

[87] Shawn D. Whiteman et al., *The Development and Implications of Peer Emotional Support for Student Service Members/Veterans and Civilian College Students*, 60 J. COUNS. PSYCHOL. 265, 267 (2013).

[88] Laura L. Carstensen, *Social and Emotional Patterns in Adulthood: Support for Socioemotional Selectivity Theory*, 7 PSYCHOL. & AGING 331, 332 (1992).

[89] *Id.*

[90] Deborah Belle, *Gender Differences in the Social Moderators of Stress*, In: ROSALIND CHAIT BARNETT ET AL., (EDS.), GENDER AND STRESS 257 (1987); Sally A. Shumaker & D. Robin Hill, *Gender Differences in Social Support and Physical Health*, 10 HEALTH PSYCH. 102, *passim* (1991).

[91] Shumaker & Hill, *supra* note 90.

surprising, given the presence of a largely loving, stable relationship.[92]

The positive impact of social support on physical and mental health cannot be understated. It has been found to relate to better overall mental health in the general population, including lower rates of depression and anxiety,[93] as well as decreased rates of overall mortality.[94] There are also some longitudinal studies that demonstrated a relationship between social support and psychological well-being. For example, a study by Galambos, Barker, & Krahn revealed that increases in social support in participants from age 18 to age 25 were related to greater self-esteem and fewer symptoms of depression.[95] Similarly, Holahan & Moos found that decreases in social support correlated with significant increases in psychological maladjustment over a 1-year period.[96] More specifically, research by Elliott et al. found that student service members/veterans reporting greater social support from family and friends (including university friends) experienced less frequent Post Traumatic Stress Disorder symptoms.[97]

For college students, having positive peer-group interactions plays an important role in social integration to university life,[98] which is, in turn, one of the most important predictors of student persistence. Unfortunately, because of their different demographics and military-specific experiences, such as combat, student service members/veterans often feel disconnected from the majority of other students in institutions of higher education.[99] More commonly, older and married students with children, may have a more difficult time relating to their

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[92] Naomi Gerstel et al., *Explaining the Symptomology of Separated and Divorced Women and Men: The Role of Material Conditions and Social Support*, 64 SOC. FORCES 84, 89 (1985).

[93] Jennifer J. Hefner & Daniel Eisenberg, *Social Support and mental health among college students*, 79 AM. J. ORTHOPSY. 491, 497 (2009).

[94] Thomas T. Rutledge, et al., *Social Networks are Associated with Lower Mortality Rates Among Women with Suspected Coronary Disease: The National Heart, Lung, and Blood Institute-sponsored Women's Ischemia Syndrome Evaluation study*, 66 PSYCHOSOMATIC MED., 882, 882 (2004).

[95] Nancy L. Galambos NL et al., *Depression, Self-Esteem, and Anger in Emerging Adulthood: Seven-Year Trajectories*, 42 DEV. PSYCHOL. 350, 350 (2006).

[96] Charles J. Holahan & Rudolf H. Moos, *Social Support and Psychological Distress: A Longitudinal Analysis*, 90 J. ABNORMAL PSYCHOL., 365, 365 (1981).

[97] Marta Elliott, et al., *U.S. Military Veterans Transition to College: Combat, PTSD, and Alienation on Campus*, 48 J. OF STUDENT AFFAIRS RES. & PRACTICE 279, 286 (2011).

[98] Leslie R.M. Hausmann, et al., *Sense of Belonging as a Predictor of Intentions to Persist Among African American and White First-Year College Students*, 48 RES. IN HIGHER ED., 803, 830 (2007).

[99] *Id.*

peers due to perceived differing levels of maturity.[100] Since many of these SSM/V are recently returning from deployment, they are also dealing with the additional stress of reintegrating into civilian life.[101] Multiple studies have documented potential sources of conflict between SSM/V and civilian peers and faculty members, including upsetting interactions related to opposing geopolitical and wartime views.[102] For reasons such as these, SSM/V have identified developing interpersonal relationships with their university peers as being particularly stressful and difficult, which in turn leads to decreased social support.[103]

Researchers often divide social support into two overarching categories: psychological (appraisal and emotional) and nonpsychological (material and instrumental).[104] In her review, Thoits noted "perceived emotional support is associated directly with better physical and mental health *and* usually buffers the damaging mental and physical health impacts of major life events and chronic strain."[105] Interestingly, *perception* of availability of emotional support appears to provide a greater impact on coping with stressors than actual support

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[100] David DiRamio et al., *From Combat to Campus: Voices of Student-Veterans*, 45 NASPA J., 73, 87 (2008). ("While the ages of the participants in this study were not drastically different from other students, there exists a difference in level of maturity that comes from wartime military service. One student, an Army veteran, noted, "I've just seen so much more than most of the college students here. I've traveled around the world. I've been given so much more responsibility and leadership. I feel that it's helped me out quite a bit").

[101] *Id.* at 86. (A student veteran recalls, "I remember when I first came home people were hugging me and all sorts of crap. It was one of those things. It was kinda [sic] nice. Now it feels very—what's the word I'm looking for?—unimportant. Something like that. The big transition was coming back from war into regular life").

[102] Elliott, *supra* note 97.

[103] DiRamio et al., *supra* note 100, at 87. ("Several students even described irritation and impatience with their less mature civilian peers. A Marine commented, 'Most [students] kind of whine over nothing. They don't really know what it is to have a hard time . . . They don't have people screaming at them to get things done at three in the morning. They sit in a sheltered dorm room and do home-work. It's not too hard. You hear people complaining and you're just like, why are you complaining?'").

[104] Sidney Cobb, *Social Support as a Moderator of Life Stress*, 38 PSYCHOSOMATIC MED., 300, # (1976); Sheldon Cohen & Garth McKay, *Social Support, Stress and the Buffering Hypothesis: A Theoretical Analysis,* 253*,* In: A ANDREW BAUM ET AL., (EDS.). HANDBOOK OF PSYCHOLOGY AND HEALTH (1984) (See page 255, "Psychological support refers to the provision of information while nonpsychological or tangible support refers to the provision of material aid. Psychological supports have further been divided into appraisal supports which contribute to one's body of knowledge or cognitive system and emotional supports which contribute to meeting one's basic social-emotional needs"); Hans O.F. Veiel, *Dimensions of Social Support: A Conceptual Framework for Research*, 20 SOC. PSYCHIATRY 156, # (1985).

[105] Peggy A. Thoits, *Stress, Coping and Social Support Processes: Where are we? What next?* 35 J. OF HEALTH & SOC. BEHAV. 53, 64 (1995).

received.[106] Through a series of interviews with SSM/V, DiRamio and colleagues found that, unfortunately, many of them perceive that emotional support from peers and staff is unavailable.[107]

In 2013, Whiteman and colleagues examined the relationship between emotional support and mental health and academic performance in SSM/V and civilian students.[108] They found that, at baseline, older, male, part-time, and veteran students reported less emotional support from university friends, while women and unmarried participants reported greater psychological distress.[109] On average, emotional support increased over the three semesters during which participants were followed, and there was no significant difference in the rate of increase between civilians and SSM/V.[110] For this reason, SSM/V never reached the same level of peer emotional support as civilian students.[111] Irrespective of military status, students with more peer emotional support reported higher GPAs, less academic motivation, and higher self-efficacy and persistence.[112] On the other hand, higher reports of peer emotional support only appeared to buffer psychological distress among civilian students.[113] Student service members/veterans seemed to have received minimal benefit.[114]

The authors of the above study ultimately concluded that "emotional support from peers may be insufficient to buffer against the psychological problems prevalent among student service members/veterans" and, therefore, campus counseling centers may need to take a more active role in addressing veteran-specific needs.[115] Their conclusion is further supported by research that suggests SSM/V may be less likely to seek out university counseling center services

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[106] Elaine Wethington & Ronald C. Kessler. *Perceived Support, Received Support, and Adjustment to Stressful Life Events,* 27, J. OF HEALTH & SOC. BEHAV., 78 (1986). ("Perceived support is, in general, more important than received support in predicting adjustment to stressful life events. . .Also the influence of received support may be mediated by perceived support").

[107] DiRamio et al., *supra* note 100.

[108] Whiteman et al., *supra* note 87.

[109] *Id.* at 271 ("Older, male, and part-time students reported less emotional support from university friends." See also Table 2. "In general, women and unmarried participants reported greater psychological distress." See also Table 3).

[110] *Id.* at 271.

[111] *Id.*

[112] *Id.* at 272, 274-75 (Tables 5 and 6).

[113] *Id.*

[114] *Id.* at 273.

[115] *Id.* at 274.

relative to civilian students.[116] This behavior may be related to their perception that there is insufficient guidance and information about how to navigate the institutional bureaucracy necessary to obtain their benefits.[117]

Academic Performance

The benefits of having good social support are not only limited to maintaining good mental and physical health. Support, particularly from peers, also corresponds with grade-point average (GPA) and retention of college students.[118] This is important to note, since student service members/veterans, on average, have lower GPAs than civilian students.[119]

A recent study by Ness et al. provided some insight into how these two variables may be related.[120] Their research examined the relationship between PTSD symptoms, positive relations, and self-regulated learning in student service members/veterans.[121] The authors chose this social-cognitive framework, because prior research demonstrated self-regulation, which is "a student's capacity to learn, use, and modify cognitions and motivations during academic work",[122] plays a strong role in academic achievement in post-secondary institutions.[123] It can be operationalized through behaviors like optimizing study environment, seeking help when needed, and organizing, in addition to a positive motivational orientation.[124] An

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116 Ted C. Bonar & Paula L. Domenici, *Counseling and Connecting with Military Undergraduates: The Intersection of the Military Service and University Life*, 25 J. OF COLLEGE STUDENT PSYCHOTHERAPY, 204 205 (2011).

117 DiRamio et al., *supra* note 100, at 91.

118 Steven B. Robbins et al., *Do Psychosocial and Study Skill Factors Predict College Outcomes? A Meta-Analysis*, 130 PSYCHOL. BULL. 261, 261 (2004).

119 Nathan Durdella & Young K. Kim, *Understanding Patterns of College Outcomes Among Student Veterans*, 2 J. OF STUDIES IN ED. 109, 116 (2012). ("Student veterans report lower college GPAs and lower levels of sense of belonging on campus in spite of having higher levels of academic participation and interaction, academic time, and collaborative work compared to their counterparts who are not veterans").

120 Bryan M. Ness et al., *Examining the Effects of Self-Reported PTSD Symptoms and Positive Relations with Others on Self-Regulated Learning for Student Service Members/Veterans,* 63 J AM COLL HEALTH 448, 448 (2015).

121 *Id.*

122 *Id.*

123 Anastasia Kitsantas et al., *Self-Regulation and Ability Predictors of Academic Success During College: A Predictive Validity Study*, 20 J. ADVANCED ACAD. 42, *passim* (2008).

124 Barry J. Zimmerman, *Investigating Self-Regulation and Motivation: Historical Background, Methodological Developments, and Future Prospects*, 45 AM. EDUC. RES. 166,

example of the latter would be a student who is motivated to study in order to increase their knowledge of a subject or to perform at the level of their peers, rather than one who studies in order to avoid appearing incompetent in class. For these reasons, one can see how peer interactions facilitate self-regulation strategies. One can also see why individuals with PTSD, which is associated with anxiety in social situations, avoidant behavior, generalized negative appraisal, and difficulty controlling affect could also present with poor self-regulation in an academic setting.[125] The results of the study confirmed this theory. Greater levels of PTSD symptoms were associated with maladaptive academic motivations and beliefs that they could not completely control their academic performance.[126]

Errors of attribution are highly common in individuals with depression, PTSD, and various anxiety disorders.[127] For example, a veteran who experiences panic symptoms during a lecture may believe they are due to his professor calling on him to answer a question. In reality, being called upon may be triggering a flashback, manifested as anxious affect and physiological arousal, without explicit recall of the episodic memory of when he witnessed the death of a fellow soldier during combat. Subsequently, this misattribution could lead the veteran to avoid answering questions in class, or worse, avoid class altogether. Fortunately, having positive perception of peer relations seemed to buffer the detrimental relationship between PTSD symptoms and, specifically, performance-avoid goals (i.e. not appearing incompetent).[128]

CURRENT AVAILABLE RESOURCES

Although resources specifically for student service members/veterans are overall inadequate, many academic institutions are currently putting forth efforts to alleviate this problem.[129] For example, in the 2013 Association for University and College

166 (2008), http://aer.sagepub.com/cgi/content/abstract/45/1/166.

125 *Id.*

126 Ness et al., *supra* note 120, at 455

127 *Id.*

128 *Id.*

129 DAVID R. REETZ ET AL., ASSOCIATION FOR UNIVERSITY AND COLLEGE COUNSELING CENTER DIRECTORS ANNUAL SURVEY, REPORTING PERIOD: SEPTEMBER 1, 2012 THROUGH AUGUST 31, 2013, AUCCCD, 2 (2013), http://files.cmcglobal.com/AUCCCD_Monograph_Public_2013.pdf.

Counseling Center Directors (AUCCCD) survey, 64.4% of directors reported that psychiatric services are offered on their campus, up from 60% in 2012.[130] It also showed some form of tele-psychology was offered by 5.5% of counseling centers, a large jump from 0.3% in 2012.[131] Another report published by the American Council on Education noted that, of the institutions of higher education which provide programs and service specifically for SSM/V, 84% provided counseling for post traumatic stress disorder, 55% have services for those with physical disabilities, and 35% have services for those with traumatic brain injuries.[132] Unfortunately, there is still a significant disconnect with SSM/V with mental illness, who utilize mental health services at even lower rates than non-student service members/veterans (47% versus 56%, respectively).[133]

Beyond mental health services, many universities offer assistance and accommodations in various other forms.[134] Of the institutions that offered any resources specifically for SSM/V, two-thirds offered financial aid/tuition counseling and another two-thirds held social/cultural events.[135] Since the GI Bill was not always adequate in covering the costs of attending college, some institutions offered scholarships for student veterans (33%) and service members (24%).[136] The vast majority of institutions offered some sort of options to accommodate for nontraditional schedules, most often evening,

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[130] *Id.* at 12. ("Sixty-four percent of directors reported that psychiatric services are offered on their campus, up from 60% in 2012").

[131] *Id.* ("Some form of tele-psychology was offered by 5.5% of counseling centers, up from .3% in 2012").

[132] MCBAIN ET AL., *supra* note 3, at 8 ("Eighty-four percent of all institutions that offer services for veterans and military personnel provide counseling to assist these students with post-traumatic stress disorder. . . 55 percent and 35 percent of institutions respectively reported having staff trained to assist veterans" with physical disabilities and TBI, respectively").

[133] Erin E. Bonar et al., *Student and Nonstudent National Guard Service Members/Veterans and Their Use of Services for Mental Health Symptoms*, 63 J. AM. COLL. HEALTH, 437, 437 (2015). ("Students and nonstudents with mental health symptoms had low levels of mental health service use (eg, Department of Veterans Affairs [VA], civilian, or military facilities), at 47% and 57%, respectively. Fewer students used VA mental health services").

[134] MCBAIN ET AL., *supra* note 3, at 9.

[135] *Id.* at 20. ("Almost all campuses that have services for veterans and service members offer some type of student services or academic support designed specifically for these students. Aside from VA education benefits counseling, the most frequently cited services were financial aid/tuition assistance counseling (67 percent versus 57 percent in 2009), special campus social and/or cultural events (66 percent versus 35 percent in 2009), and employment assistance (61 percent versus 49 percent in 2009)").

[136] *Id.* at 8.

weekend, online, or hybrid face-to-face and online classes.[137] Eighty-three percent offered credits for military training, while 63% offered credits for military occupational experience.[138] Most also have developed policies which allow the student to postpone classes or be refunded their tuition if they are deployed.[139] Reinstated in 2008, the Higher Education Opportunity Act specifies that, with few exceptions, institutions must reinstate deployed service members, without change in academic status, if the service-related absence is no longer than five years.[140] The service member must also notify the institution within a designated timeframe of, typically, three years.[141] However, this process often becomes muddled for bureaucratic reasons. For example, 48% of institutions require these students to go through the standard re-enrollment process, while 17% require students to reapply.[142] The reapplication process delays their reintegration into civilian life, creates stress, and unnecessarily penalizes SSM/V for their service.

As described above, positive peer relationships play a vital role in successful transition to college life and academic performance.[143] Student service members/veterans consistently list connection with their military peers as a desired means of support,[144] yet less than half of institutions include a veteran-specific orientation or dedicated lounge or gathering space.[145] On the other hand, between 2009 and 2012, the percentage of institutions with veteran/military student organizations and support groups more than doubled, rising from 32 to 68% and 18 to 42%, respectively.[146]

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137 *Id.* at 19.

138 *Id.* at 19.

139 *Id.* at 19-20. (The HEOA "requires institutions of higher education to readmit service members without a change in academic status if the service-related absence does not exceed five years (though some exceptions apply) and if the service member notifies the institution of intent to re-enroll within a prescribed time frame (generally three years, though there are exceptions for those recovering from service-related injuries)").

140 *Id.* at 20.

141 *Id.*

142 *Id.* at 55.

143 Whiteman et al., *supra* note 87, at 266.

144 MCBAIN ET AL., *supra* note 3, at 12. ("[Students] pressed high regard for opportunities to interact with fellow student veterans and have access to campus staff who are trained in and sensitive to the unique issues veterans face. Institutions will have to continue making their own determinations—ideally in close consultation with their veteran students—about which services merit a special focus on veterans, military personnel, and their families").

145 *Id.* at 20.

146 *Id.* at 22.

RECOMMENDATIONS

There are a number of unique issues that student service members/veterans face while attending post-secondary academic institutions.[147] While some may have acquired physical disabilities during their time serving our country, almost half suffer from depression, anxiety, post traumatic stress, traumatic brain injuries, and/or substance dependence.[148] These psychiatric comorbidities often create significant impairment in social and academic function, as well as contribute to violent behavior toward others and themselves.[149] However, difficulties adjusting to college life are not limited to those with psychiatric problems. Due to differences in demographics and military-related experiences compared to the general university population, SSM/V often feel alienated from their peers and uncomfortable interacting with faculty.[150] This then contributes to difficulties navigating the university infrastructure and bureaucracy, as well as underutilization of the already limited resources available to them.[151]

Since the GI Bill was enacted in 2009, colleges and universities have demonstrated increased interest in the special needs of this subpopulation of students, with many Student Veteran Service Centers emerging nationally.[152] However, to our knowledge, there have not been any studies examining how prepared these institutions really are to address these needs. For the reasons outlined above, it would be prudent for faculty in the administrative, academic, and counseling departments to have specific training to increase their awareness of these issues. Didactics should include the descriptions of the types of experiences service members face during their training and deployment in order to promote empathy and sensitivity about military-related

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147 Adam E. Barry et al., *Student Service Members/Veterans in Higher Education: A Systematic Review*, 51 J. STUD. AFF. RES. PRACT. 30, 30 (2014).

148 *Id.* at 33.

149 John R. Blosnich et al., *Mental Health and Self-Directed Violence Among Student Service Members/Veterans in Postsecondary Education*, 63 J. AM. COLL. HEALTH 418, 418 (2015). ("Student service members/veterans had higher odds of self-harm than students without military experience. Among student service members/veterans, hazardous duty was positively associated (odds ratio [OR] = 2.00, 95% confidence interval [CI] [1.30, 3.07]) with having a psychiatric diagnosis but negatively associated (OR = 0.41, 95% CI [0.20, 0.85]) with suicidal ideation").

150 Barry et al., *supra* note 147, at 37-38.

151 DiRamio et al., *supra* note 100, at 97.

152 MCBAIN ET AL., *supra* note 3, at 15.

subjects. Furthermore, staff at all levels should be educated about signs and symptoms of depression, post traumatic stress disorder, and substance abuse, which are common among service members/veterans, and significantly increase their risk of suicide. Since so few of the SSM/V who suffer from mental illness seek treatment, teachers are often put on the frontlines of identifying students who need help. By training employees campus-wide, from custodians to librarians, to recognize "potentially dangerous behavior," Cornell University was able to decrease its number of suicides from 11 in six years to five in the six years after implementing the changes.[153]

At an administrative level, we encourage creating regulations that accommodate the demands inherent in being a service member. For example, we support enacting a system for expedited re-enrollment for SSM/V returning from deployment. We also believe that colleges should value relevant training and job experience obtained during enlistment by awarding comparable credit hours. Similarly, the option to "test out" of certain classes can minimize redundancy between military and college education. Depending on the demand at a particular institution, we encourage allocating funds to create a dedicated space for SSM/V to work and socialize. Furthermore, therapy groups or student organizations, which facilitate development of a peer support system, could also utilize such an area. As earlier discussed, peer support plays an incredibly significant role in academic success and overall mental health.[154] Therefore, we recommend implementing a peer-mentor program, in which freshmen are paired with a more senior SSM/V. Not only does this create a direct lifeline, but it may also create a more comfortable means of networking with other SSM/V on campus.

Administrators should also coordinate with professors to create a supportive culture for student service members/veterans. As previously described, posttraumatic stress disorder, depression, and traumatic brain injuries often cause significant cognitive and interpersonal impairment, which may create problems in a standard university

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[153] Elizabeth Bernstein, *Bucking Privacy Concerns, Cornell Acts as Watchdog*, WALL STREET J. (Dec. 28, 2007), http://www.wsj.com/articles/SB119881134406054777 (Cornell University has an "'alert team' of administrators, campus police and counselors meets weekly to compare notes on signs of student emotional problems. People across campus, from librarians to handymen, are trained to recognize potentially dangerous behavior. . . In the last six years since Cornell took it first new steps in 2002, the school has had five student suicides, it says. In the previous six years, there were 11").

[154] Whiteman et al., *supra* note 87; Hausmann, et al., *supra* note 98, at 1.

setting.[155] For example, the hyperviligance and hypersensitivity to noise associated with PTSD can make focusing on a test or lecturer quite difficult in a large auditorium. Therefore, allowing the student to study and take the test separately in a small classroom would yield exam scores more reflective of their acquired knowledge. Additionally, we would encourage offering additional time for those limited by attention or processing speed deficits associated with TBI. Lastly, in circumstances where the SSM/V must interact with faculty or peers, educators should be patient and understanding of any interpersonal deficits, which are common in persons with PTSD, TBI, and depression. Creating a safe, nonjudgmental environment allows them to develop more positive perceptions of their peer relationships, which, in turn, leads to better academic achievement and satisfaction.

An in depth discussion of all the types of therapy used to treat depression and post-traumatic stress disorder would be beyond the scope of this review. However, the two most effective techniques for combat-related PTSD are cognitive reprocessing and exposure therapy.[156] The former serves as a means of rewriting the internal narrative one associates with a traumatic event.[157] For example, a veteran may endorse negative appraisal of the world around him after witnessing the bombing of an entire village. Through cognitive reprocessing, his beliefs gradually change from "life is chaotic, confusing, and inherently destructive" to "the deaths of those villagers were tragic, but there are plenty of good people and events in the world."[158] Making meaning of stressful events, which can be part of cognitive restructuring, also can reduce suicidal ideation.[159]

Exposure therapy, on the other hand, works through classical conditioning.[160] By repeatedly and deliberately instructing the veteran to describe the traumatic memory, the therapist exposes them to it in a safe environment. After several sessions, their conditioned emotional response of extreme fear or anxiety gradually diminishes as their mind decouples the trigger (conditioned stimulus; e.g. any sudden noise)

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[155] Tanielian & Jaycox, *supra* note 6; Rudd et al., *supra* note 31; Heiligenstein & Guenther, *supra* note 37; Hoge et al., *supra* note 56.

[156] John N. Briere & Catherine Scott, *Principles of Trauma Therapy: A Guide to Symptoms, Evaluation, and Treatment, 2nd ed.*, SAGE Publications (2015).

[157] *Id.*

[158] *Id.*

[159] *Id.*

[160] *Id.*

from the actual threat (unconditioned stimulus; e.g. gunfire).[161]

Based on a systematic review of 112 studies, Cicerone and colleagues provided some recommendations for treatment of individuals with traumatic brain injuries.[162] First, they supported using direct attention and metacognitive training in order to foster the development of self-directed strategies, which also ameliorate mild memory deficits related to TBI.[163] These therapies can promote generalization to real-world tasks. For deficits in self-awareness and other types of executive functioning, cognitive behavioral therapy [CBT] can be particularly useful.[164] Since CBT has a large body of literature to support its utility in treating a host of mental disorders, it is highly recommended that campuses employ a therapist who specializes in this modality of treatment.[165] Neurologic Music Therapy is another novel treatment that may improve cognitive function and promote social interactions.[166]

In short, there are a number of ways in which college campuses can accommodate the unique needs of student service members/veterans. These include a streamlined system for accessing benefits and completing academic requirements, a means of networking with military peer support, and comprehensive mental health services for the high number of veterans suffering from depression, anxiety, PTSD, substance dependence, or TBI. Treatment modalities should be individualized based on the SSM/V's particular symptoms, but will very frequently include some form of cognitive therapy. Most importantly, colleges and universities should use education and outreach to create an environment in which SSM/V can thrive academically and feel comfortable asking for help in times of need.

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161 *Id.*

162 Keith D. Cicerone et al., *Evidence-Based Cognitive Rehabilitation: Updated Review of the Literature from 2003 through 2008*, 92, ARCH. PHYS. MED. REHABIL., 519, 519 (2011).

163 *Id.* at 520.

164 *Id.* at 521.

165 *Id.* at 522.

166 Shantala Hegde, *Music-Based Cognitive Remediation Therapy for Patients with Traumatic Brain Injury*, 5 FRONT. NEUROL. 1, 2 (2014).

INTEGRATING INTERVENTION EFFORTS INTO A STEPPED CARE MODEL TO REDUCE HEAVY COLLEGE SUBSTANCE USE AND DECREASE MENTAL HEALTH STIGMA

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Abstract

Heavy college drinking has become an area of focus among schools and organizations in recent years. However, most colleges and universities do not have consistent policies to handle heavy drinkers, particularly those who are in need of a higher level of care than those with lower drinking levels. Many studies have examined different approaches to dealing with the issue, but they have largely been in the context of widespread intervention efforts and have not addressed those who do not respond to such interventions. The goal of this paper is to synthesize the literature on college drinking to provide a framework for colleges and school administrators to offer and refer services to students. The first part of the paper will separately review three interrelated areas of literature: heavy college drinking, intervention and policy efforts, and mental health stigma as a barrier to treatment. The second part of this paper integrates these topics within the context of a stepped care approach and presents abstinence and harm reduction treatment modalities as options for those who do not respond to current intervention efforts. This paper argues that the utility of abstinence and harm-reduction approaches is not black and white, but that the utility depends on the person and the context in which the intervention is implemented. A stepped care approach sees intervention as a dynamic process that moves in different directions depending on a client's responses to other interventions. Additionally, a stepped care approach is presented as a conceptual model to compare and contrast abstinence and harm reduction treatments and this paper argues that presenting and offering students more diffuse treatment options may motivate students to seek treatment, which may in turn, normalize the occurrence of substance use treatment and reduce mental health stigma.

1. Current Objectives

Existing literature on heavy college drinking has been informative but limited. To date, research has separately examined college drinking, policies to decrease heavy alcohol use, and how mental health stigma is a related barrier towards receiving treatment. However, there has yet to be a synthesis of the literature for colleges

and universities to create a system that benefits the school and community from a public health perspective (e.g. decreased episodes of drinking and driving) but also students in helping them reach their goal of graduation (e.g. through decreased time spent obtaining drinks or drinking and potentially more time to spend studying). The present review takes a trans-disciplinary approach to issues surrounding heavy college drinking. This paper critically reviews and integrates these diverse perspectives to argue for a stepped-care policy model for colleges to prevent and intervene on substance use issues.

2. Introduction

The first half of this paper will review three distinct areas of research: heavy college drinking, policies and intervention efforts implemented by colleges, as well as mental health stigma as a barrier towards receiving services. Although substance use issues are prevalent across the lifespan, college was chosen as an area of focus for this paper given the prevalence of heavy drinking as well as the developmentally normative nature of substance use throughout this period.[1] Colleges nationwide have recognized heavy drinking as a problem on campus and the majority has enlisted some type of alcohol abuse prevention program.[2] Approximately 90% of colleges provide some counseling or treatment service.[3]

2.1 Heavy Alcohol Use in College Students: The Problem

Across numerous epidemiological studies, an estimated 40% of college students are considered current heavy drinkers.[4] Heavy drinking has been described as having five or more drinks in a row for

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[1] *See generally* John E Schulenberg, *A Developmental Perspective on Alcohol Use and Heavy Drinking During Adolescence and the Transition to Young Adulthood*, s14 J. OF STUDIES ON ALCOHOL, Supplement, 54–70 (2002).

[2] *See* Henry Wechsler, Mark Seibring, I-Chao Liu, & Marilyn Ahl, Colleges Respond to Student Binge Drinking: Reducing Student Demand or Limiting Access, *52* J. OF AM. COLLEGE HEALTH 159, 159-168 (2004), http://archive.sph.harvard.edu/cas/Documents/respond/respondingg-1.pdf.

[3] *Id.*

[4] O'Malley, P. M., & Johnston, L. D. (2002). Epidemiology of alcohol and other drug use among American college students. *Journal of Studies on Alcohol, 14*, 23-39; Wechsler, H., Davenport, A., Dowdall, G., Moeykens, B., & Castillo, S. (1994). Health and behavioral consequences of binge drinking in college: A national survey of students at 140 campuses. *Journal of American Medical Association, 272*, 1672-77.

men and four for women[5] This is consistent with the National Institute of Alcohol Abuse and Alcoholism's binge drinking definition, which is defined as having at least five drinks within a two-hour period for men and four drinks for women.[6] On average, this level of drinking brings an individual's blood alcohol concentration to approximately 0.08g/dl, which is the legal driving limit in the United States.[7]

College and early adulthood is a particularly risky period for heavy alcohol use with heavy drinking increasing after high school graduation for both college and non-college bound students.[8] However, college students increase more than the non-college students and actually surpass their nonstudent age-mates.[9] An estimated 18% of US college students (24% of men and 13% of women) meet clinically significant levels for alcohol-related problems based on DSM-IV diagnoses.[10] This is greater than non-college attending peers where 22% of men and 9% of women meet criteria for Alcohol Abuse or Dependence. It is throughout this period that alcohol use tends to peak before subsiding as individuals move into adulthood roles with careers and serious relationships[11]

The high prevalence of heavy drinking in college students poses a significant public health concern with binge drinkers and heavy episodic drinkers being more likely to experience alcohol-related problems.[12] Heavy drinking is associated with a number of adverse

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[5] Wechsler, H., & Nelson, T. F. (2001). Binge drinking and the American college student: What's five drinks? *Psychology of Addictive Behaviors, 15*, 287-91.

[6] National Institute on Alcohol Abuse and Alcoholism, Drinking Levels Defined (http://www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/moderate-binge-drinking).

[7] *Id.*

[8] O'Malley, P. M., & Johnston, L. D. (2002). Epidemiology of alcohol and other drug use among American college students. *Journal of Studies on Alcohol, Supplement*, (14), 23-39.

[9] O'Malley, P. M., & Johnston, L. D. (2002). Epidemiology of alcohol and other drug use among American college students. *Journal of Studies on Alcohol, 14*, 23-39; Slutske, W. S. (2005). Alcohol use disorders among US college students and their non–college-attending peers. *Archives of General Psychiatry*, *62*, 321-27.; Wu, L. T., Pilowsky, D. J., Schlenger, W. E., & Hasin, D. (2007). Alcohol use disorders and the use of treatment services among college-age young adults. *Psychiatric Services, 58*, 192-200.

[10] Slutske, W. S. (2005). Alcohol use disorders among US college students and their non–college-attending peers. *Archives of General Psychiatry*, *62*, 321-27.

[11] Schulenberg, J. E., & Maggs, J. L. (2002). A developmental perspective on alcohol use and heavy drinking during adolescence and the transition to young adulthood. *Journal of Studies on Alcohol* Supplement*, 14*, 54-70.

[12] Wechsler, H., Lee, J. E., Kuo, M., Lee, H. (2000). College binge drinking in the 1990s: A continuing problem. Results of the Harvard School of Public Health 1999 College Alcohol Study. *Journal of American College Health, 48*, 199-210.

health, educational, and social consequences, including physical injury, high-risk sexual behavior, alcohol overdose, alcohol-impaired driving, psychosocial problems, antisocial behaviors, and academic difficulties.[13] In one year alone, it was estimated that 2 million of the 8 million college students in the United Stated reported driving under the influence. Three million were estimated to be in the car with a drinking driver.[14] Additionally, an estimated 500,000 college students aged 18-24 suffered unintentional injuries under the influence of alcohol, approximately 1,400 died from alcohol related unintentional injuries, 600,000 were assaulted, and 70,000 were victims of sexual assault or date rape.

Despite those considered "heavy drinkers" being an at-risk group for many consequences, it is not a homogenous group. Within the United States itself, white students are more often reported to be heavy drinkers than both black and Hispanic students.[15] Males, in particular, tend to drink more in America and across a number of other cultures, such as the Czech Republic, Netherlands, Australia, and Russia.[16] Males also experience more consequences for themselves and others around them that involve public deviance (e.g. getting into a fight at the bar) compared to females.[17] Women tend to experience fewer alcohol-related problems than men, which may be due to several reasons: (1) women perceive greater social sanctions for drinking, (2) women are less likely to have characteristics associated with excessive

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[13] Perkins, H. W. (2002). Surveying the damage: A review of research on consequences of alcohol misuse in college populations. *Journal of Studies on Alcohol* Supplement*, 14*, 91-100; Wechsler, H., Dowdall, G. W., Maenner, G., Gledhill-Hoyt, J., & Lee, H. (1998). Changes in binge drinking and related problems among American college. *Journal of American College Health, 47*, 57-68.; Wechsler, H., Lee, J. E., Kuo, M., Lee, H. (2000). College binge drinking in the 1990s: A continuing problem. Results of the Harvard School of Public Health 1999 College Alcohol Study. *Journal of American College Health, 48*, 199-210.

[14] Hingson, R. W., Heeren, T., Zakocs, R. C., Kopstein, A., & Wechsler, H. (2002). Magnitude of alcohol-related mortality and morbidity among U.S. college students ages 18-24. *Journal of Studies on Alcohol, 63*, 136-144.

[15] O'Malley, P. M., & Johnston, L. D. (2002). Epidemiology of alcohol and other drug use among American college students. *Journal of Studies on Alcohol, 14*, 23-39; Siebert, D. C., Wilke, D. J., Delva, J., Smith, M. P., & Howell, R. L. (2003). Differences in African American and White college students' drinking behaviors: Consequences, harm reduction strategies, and health information sources. *Journal of American College Health, 52*, 123-29.

[16] O'Malley, P. M., & Johnston, L. D. (2002). Epidemiology of alcohol and other drug use among American college students. *Journal of Studies on Alcohol, 14*, 23-39; Wilsnack, R. W., Vogeltanz, N. D., Wilsnack, S. C., & Harris, T. R. (2000). Gender differences in alcohol consumption and adverse drinking consequences: cross-cultural patterns. *Addiction, 95*, 251-65.

[17] Perkins, H. W. (2002). Surveying the damage: A review of research on consequences of alcohol misuse in college populations. *Journal of Studies on Alcohol* Supplement*, 14*, 91-100.

drinking, including aggressiveness, drinking to reduce distress, behavioral under-control, sensation-seeking, and anti-sociality, and (3) women are more likely to have desirable feminine traits (e.g., nurturance) protective against excessive drinking.[18] These individual differences suggest a need for interventions focused on those at greater risk. It is also critical to recognize that despite certain groups or individuals being at lower risk, no one group is immune from alcohol-related problems.

2.2 Policy and Intervention Efforts

The magnitude of heavy college drinking has gained national attention in previous years. Congress passed resolutions asking college presidents to take steps to address this problem.[19] The US Surgeon General established a national health goal of reducing college binge drinking by 50% by the year 2010.[20] The National Institute on Alcoholism and Alcohol Abuse (NIAAA) formed a special task force to make recommendations to address the heavy drinking problem among college students.[21] Despite efforts to reduce drinking, heavy college drinking is still problematic. Heavy drinking prevalences remained roughly the same from 1993 to 2009 with 37% of college students reporting binge drinking in 2009.[22]

Given the national attention placed on policy efforts, psychology researchers have provided suggestions to dealing with heavy drinking. The Harvard School of Public Health College Alcohol Study sought to provide the first nationally representative picture of college student alcohol use and to describe drinking patterns of heavy users[23] This

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[18] Nolen-Hoeksema, S. (2004). Gender differences in risk factors and consequences for alcohol use and problems. *Clinical Psychology Review, 24*, 981-1010.

[19] Higher Education Reauthorization Act of 1998, H. R. 321, 105h Cong., 2nd Sess. (1998).

[20] U.S. Department of Health and Human Services. Healthy People 2010. With Understanding and Improving Health and Objectives for Improving Health. 2. II. Washington, D.C.: U.S. Government Printing Office; 2000.

[21] Boyd, G. M., & Faden, V. Overview. *Journal of Studies on Alcohol*, Supplement No. 14, 6-13; Task Force of the National Advisory Council on Alcohol Abuse and Alcoholism (NIAAA). Call to Action: Changing the Culture of Drinking at U.S. Colleges, NIH Publication No. 02-5010, Bethesda, MD: Department of Health and Human Services, 2002 (http://www.collegedirnkingprevention.gov).

[22] Johnston, L. D., O'Malley, P. M., Bachman, J. G., Schulenberg, J. E. (2010). Monitoring the Future: National survey results on drug use, 1975-2009. Bethesda, MD: National Institute on Drug Abuse.

[23] Wechsler, H., Dowdall, G. W., Maenner, G., Gledhill-Hoyt, J., & Lee, H. (1998).

study's findings on college alcohol use led to five main implications towards prevention: (1) the need to focus on those at drinking levels lower than what would be considered "intoxicated", (2) the harms produced at this lower level of drinking, (3) the second hand effects experienced by other students and neighborhood residents, (4) the continuing extent of the problem, (5) the role of college alcohol environment in promoting heavy drinking by students[24]

Similarly, policy researchers have offered colleges several areas to focus on to reduce heavy drinking, including: (1) reducing alcohol use and related problems among underage college students (e.g. decrease social and commercial access to alcohol), (2) reducing risky alcohol use and related problems among all college students (e.g. increase price of alcohol, restrict where alcohol is consumed), and (3) de-emphasizing the role of alcohol and creating positive expectations on campus. These approaches have been taken into consideration and many related policies have been implemented on both the college-level[25] and national level[26]

The implications and prevention efforts proposed by both the psychology and policy researchers highlight the diverse treatment areas for colleges to target. The cited recommendations emphasize the heterogeneous nature of substance use in colleges and the importance of broadening the intervention focus to not just those experiencing the greatest amount of alcohol-related consequences, but those at all levels.

Changes in binge drinking and related problems among American college. *Journal of American College Health, 47*, 57-68; Wechsler, H., & Nelson, T. F. (2008). What we have learned from the Harvard School of Public Health College Alcohol Study: Focusing attention on college student alcohol consumption and the environmental conditions that promote it. *Journal of Studies on Alcohol and Drugs*, *69*, 481-90.

[24] Wechsler, H., & Nelson, T. F. (2008). What we have learned from the Harvard School of Public Health College Alcohol Study: Focusing attention on college student alcohol consumption and the environmental conditions that promote it. *Journal of Studies on Alcohol and Drugs*, *69*, 481-90.

[25] Kilmer, J. R., Larimer, M. E., Parks, G. A., Dimeff, L. A., & Marlatt, G. A. (1999). Liability management or risk management? Evaluation of a Greek System Alcohol Policy. *Psychology of Addictive Behaviors, 13*, 269-278.; Toomey, T. L., Lenk, K. M., & Wagenaar, A. C. (2007). Environmental policies to reduce college drinking: An update of research findings. *Journal of Studies on Alcohol and Drugs, 68*, 208-19; Zhu, L., Gorman, D. M., & Horel, S. (2004). Alcohol outlet density and violence: A geospatial analysis. *Alcohol and Alcoholism, 39*, 369-75.

[26] Hingson, R., Heeren, T., & Morelock, S. (1989). Effects of Maine's 1982. 02 law to reduce teenage driving after drinking. *Alcohol, Drugs & Driving*.; Hingson, R., Heeren, T., & Winter, M. (1994). Lower legal blood alcohol limits for young drivers. *Public health reports*, *109*, 738.; Liang, L., & Huang, J. (2008). Go out or stay in? The effects of zero tolerance laws on alcohol use and drinking and driving patterns among college students. *Health Economics, 17*, 1261-75.

Colleges have used many prevention and intervention approaches to deal with heavy drinking issues.[27] To date, however, these approaches have largely focused on campus-wide interventions and not necessarily interventions targeted at students with more severe substance use problems.[28] Personalized normative feedback is one such intervention[29]

Personalized normative feedback interventions are strategies that have been widely implemented at schools to address college students' tendency to overestimate the prevalence of drinking among their peers.[30] This type of intervention has been suggested as a widespread, cost-efficient strategy that can be effective even with a single session.[31] Although personalized feedback interventions differ across schools, it can consist of several components: providing an overview of mean weekly alcohol consumption, blood alcohol concentration levels, health and social risks with problem drinking, and self-help guidelines to change problematic drinking. Normative feedback is an important component of personalized feedback whereby problem drinkers compare their own alcohol consumption to that of other members of their cohort. Thus, college students can compare their use patterns to other students at the school. Such comparisons can trigger an awareness in problem drinkers of their own patterns and potential risks and hopefully motivating them to reduce their own use[32]

Research has largely supported self-regulation models, which predict that normative re-education intervention among college students produce changes in perceived drinking norms.[33] However, this type of intervention is not a panacea. Despite the strong support for

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[27] Larimer, M. E., & Cronce, J. M. (2007). Identification, prevention, and treatment revisited: Individual-focused college drinking prevention strategies 1999–2006. *Addictive behaviors*, *32*(11), 2439-68.

[28] *Id.*

[29] Riper, H., van Straten, A., Keuken, M., Smit, F., Schippers, G., & Cuijpers, P. (2009). Curbing problem drinkers with personalized-feedback interventions: A meta-analysis. *American Journal of Preventive Medicine, 36*, 247-55.

[30] Agostinelli, G., Brown, J. M., & Miller, W. M. (1995). Effects of normative feedback on consumption among heavy drinking college students. *Journal of Drug Education, 25*, 31-40.

[31] Riper, H., van Straten, A., Keuken, M., Smit, F., Schippers, G., & Cuijpers, P. (2009). Curbing problem drinkers with personalized-feedback interventions: A meta-analysis. *American Journal of Preventive Medicine*, 36, 247-55.

[32] Larimer, M. E., Marlatt, G. A., Baer, J. S., Quigley, L. A., Blume, A. W., Hawkins, E. H. (1998). Harm reduction for alcohol problems: Expanding access to and acceptability of prevention and treatment services. In G. A. Marlatt (Ed.), *Harm Reduction: pragmatic approaches to managing high-risk behaviors* (p. 69-121). New York: Guildford Press.

[33] Larimer, M. E., & Cronce, J. M. (2007). Identification, prevention, and treatment revisited: Individual-focused college drinking prevention strategies, 1999-2006. *Addictive Behaviors, 32*, 2439-68.

these types of intervention efforts, not all research has supported the effectiveness of the campaigns.[34] In fact, it has been theorized that social norms campaigns can actually increase lower level drinking.[35] Thus, although these widespread campaigns are low cost and impact many students, they do not necessarily address a faction of the college populations that use despite such intervention efforts.

2.3 Mental Health Stigma as Barrier Towards Treatment

These statistics on the prevalence of heavy alcohol use and the lack of intervention efforts at higher levels of use are particularly concerning given few students actually seek treatment.[36] An estimated 25% of those with substance use problems actually end up receiving services.[37] Although there may be many reasons to account for the low treatment utilization among problem substance users, shame, pride, unwillingness to share problems, and the stigma of seeking treatment have all been cited as potential barriers to seeking treatment.[38]

Mental health stigma is one significant barrier towards treatment seeking.[39] This is particularly notable given that those with substance use problems are viewed more unfavorably than other mental health

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[34] Wechsler, H., Nelson, T. F., Lee, J. E., Seibring, M., Lewis, C., & Keeling, R. P. (2003). Perception and reality: A national evaluation of social norms marketing interventions to reduce college students' heavy alcohol use. *Journal of Studies on Alcohol, 64*, 484-94.

[35] Perkins, H. W., & Berkowitz, A. D. (1986). Perceiving the community norms of alcohol use among students: Some research implications for campus alcohol education programming. *International Journal of Addiction, 21*, 961-76.

[36] Blanco, C., Okuda, M., Wright, C., Hasin, D.S., Grant, B. F., Liu, S., . . . Olfson, M. (2008). Mental health of college students and their non-college-attending peers. Results from the National Epidemiologic Study on Alcohol and Related Conditions. *Archives of General Psychiatry, 65*, 1429-1437.; Knight, J. R., Wechsler, H., Kuo, M., Seibring, M., Weitzman, E. R., & Schuckit, M. A. (2002). Alcohol abuse and dependence among U.S. college students. *Journal of studies on alcohol*, *63*(3), 263-70; Wu, L. T., Pilowsky, D. J., Schlenger, W. E., & Hasin, D. (2007). Alcohol use disorders and the use of treatment services among college-age young adults. *Psychiatric Services, 58*, 192-200.

[37] Regier, D. A., Narrow, W. E., Rae, D. S., Manderscheid, R. W., Locke, B. Z., & Goodwin, F. K. (1993). The de facto US mental and addictive disorders service system: Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services. *Archives of General Psychiatry*, *50*(2), 85-94.

[38] Cunningham, J. A., Sobell, L. C., Sobell, M. B., Agrawal, S., & Toneatto, T. (1993). Barriers to treatment: Why alcohol and drug abusers delay or never seek treatment. *Addictive Behaviors, 18*, 347-53.

[39] Corrigan, P. W., & Watson, A. C. (2007). The stigma of psychiatric disorders and the gender, ethnicity, and education of the perceiver. *Community Mental Health Journal, 43*, 439-58; Pedersen, E. R., & Paves, A. P. (2014). Comparing perceived public stigma and personal stigma of mental health treatment seeking in a young adult sample. *Psychiatry research*, *219*, 143-50; Tija, J., Givens, J. L., & Shea, J. A. (2005). Factors associated with undertreatment of medical student depression. *Journal of American College Health, 53*, 219-24.

disorders.[40] Additionally, research has found that adults with alcohol use problems tend to perceive greater levels of stigma,[41] which may be related to other research suggesting that people tend not to perceive substance use disorders as "mental illnesses" and thus may be related to perception of substance use as a choice rather than a disease[42]

These issues are especially notable given that drug addiction is viewed more unfavorably than other types of mental illness, particularly among individuals in the 16-19 year old age range.[43] Those with drug addiction are viewed as more dangerous and blameworthy for their mental illness compared to those with schizophrenia, eating disorders, dementia, depression, or panic attacks. Those with alcoholism are the third highest rated group behind drug addiction and schizophrenia for dangerousness to others and second in blameworthiness behind drug addiction. It has been argued that the reason those with drug addictions tend to receive more stigma and blame than other forms of mental illness is because drug abuse is not seen as a medical condition but considered an act of personal choice.[44]

It should be noted that there are many cultural factors that must be taken into account when discussing mental health stigma. Characteristics, such as being male, younger, Asian, more religious, or coming from a poor family background have all been associated with higher personal stigma and a decreased likelihood to seek treatment for mental health problems.[45] It's been hypothesized that the lower

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[40] Crisp, A., Gelder, M., Goddard, E., & Meltzer, H. (2005). Stigmatization of people with mental illnesses: a follow-up study within the Changing Minds campaign of the Royal College of Psychiatrists. *World Psychiatry, 4*, 106-13.

[41] Link. B. G., Struening, E. L., Rahav, M., Phelan, J. C., & Nuttbrock, L. (1997). On stigma and its consequences: Evidence from a longitudinal study of men with dual diagnoses of mental illness and substance abuse. *Journal of Health and Social Behavior, 38*, 177-90; Keyes, K. M., Hatzenbuehler, M. L., McLuaghlin, K. A., Link, B., Olfson, M., Grant, B. F., . . . Hasin, D. (201). Stigma and treatment for alcohol use disorders in the United States. *American Journal of Epidemiology, 172*, 1364-72.

[42] Link, B. G., Phelan, J. C., Bresnahan, M., Stueve, A., & Pescosolido, B. A., (1999). Public conceptions of mental illness: Labels, causes, dangerousness, and social distance. *American Journal of Public Health, 89*, 1328-33.

[43] Crisp, A., Gelder, M., Goddard, E., & Meltzer, H. (2005). Stigmatization of people with mental illnesses: a follow-up study within the Changing Minds campaign of the Royal College of Psychiatrists. *World Psychiatry, 4*, 106-13.

[44] Link. B. G., Struening, E. L., Rahav, M., Phelan, J. C., & Nuttbrock, L. (1997). On stigma and its consequences: Evidence from a longitudinal study of men with dual diagnoses of mental illness and substance abuse. *Journal of Health and Social Behavior, 38*, 177-90.

[45] Corrigan, P. W., & Watson, A. C. (2007). The stigma of psychiatric disorders and the gender, ethnicity, and education of the perceiver. *Community Mental Health Journal, 43*, 439-58; Eisenberg, D., Downs, M. F., Golberstein, E., & Zivin, K. (2009). Stigma and help seeking for mental health among college students. *Medical Care Research and Review, 66*, 522-41;

endorsement of stigmatizing attitudes among females may stem from higher rates of social empathy and/or a lower need for social dominance among women compared to men.[46] Additionally, students report greater levels of perceived public stigma than personal stigma, particularly for women.[47] General negative attitudes towards treatment and anxiety symptoms are associated with perceived public stigma, whereas, being male, Asian ethnicity, and having negative attitudes towards treatment are associated with greater levels of personal stigma.

3. Integrating Research on Heavy Drinking, Policy, and Stigma

The three areas of research summarized thus far have demonstrated the prevalence of heavy drinking, points of intervention, as well as mental health stigma as a barrier to receiving treatment. Heavy college drinking is a significant problem such that schools and government officials have responded with mandates and policies to reduce use. Despite efforts, rates of heavy drinking have remained roughly the same over the past two decades and many individuals do not seek the necessary treatment. Mental health stigma may be a significant barrier with those experiencing greater stigma being less likely to receive treatment. However, research has yet to elucidate how these different topics are related and how they can be integrated into a cohesive message for colleges and universities to implement treatment services. Furthermore, research on interventions has largely focused on campus-wide programs and has yet to address the portion of students who do not respond to such efforts.

In 2001, the World Health Organization recommended viewing alcohol problems on a continuum and offering a range of prevention efforts to account for the heterogeneous nature of this serious mental health issue.[48] This idea exemplifies the "one size does not fit all" paradigm, in which, no one prevention or intervention effort is equally

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Eisenberg, D., Downs, M. F., Golberstein, E., & Zivin, K. (2009). Stigma and help seeking for mental health among college students. *Medical Care Research and Review, 66*, 522-41.

[46] Corrigan, P. W., & Watson, A. C. (2007). The stigma of psychiatric disorders and the gender, ethnicity, and education of the perceiver. *Community Mental Health Journal, 43*, 439-58.

[47] Pedersen, E. R., & Paves, A. P. (2014). Comparing perceived public stigma and personal stigma of mental health treatment seeking in a young adult sample. *Psychiatry research*, *219*, 143-50.

[48] World Health Organization. (2001). *The World Health Report 2001: Mental health: new understanding, new hope*. World Health Organization.

effective for all individuals.[49] Distinct subgroups of substance users have been found to characterize adolescent drug use (i.e. nonusers, alcohol only users, and users of multiple drugs) with unique patterns of use, numbers of problems experienced, and risk patterns.[50] From this perspective, the integration of school and community based drug prevention programs has been suggested as a way of capturing the full spectrum of patterns of use and levels of risk among adolescent student populations.[51] This is particularly important given public policy research implicating the importance of targeting individuals not just at lower use levels but those experiencing heavier consequences as well.[52] Providing a diverse set of services for those at all levels of substance use, but especially for those at higher levels, seeks to increase the number of people receiving some type of intervention service, thereby, normalizing the occurrence of behaviors, reducing harmful consequences, and ultimately reducing mental health stigma.

3.1 Stepped Care Model

A stepped-care model has been proposed as one way to treat individuals with alcohol problems at all levels.[53] This model views treatment as a dynamic process that moves in different directions depending on a client's responses to other interventions.[54] The first line of treatment can be a universally disseminated prevention effort, such as alcohol skills education, books, self-help support groups, or targeted

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[49] G. Alan Marlatt, *Harm reduction: Come as you are.* 21 Addictive Behaviors 779,785. (1996); Mark B. Sobell & Linda Carter Sobell, *Treatment for problem drinkers: A public health priority*. Addictive Behaviors across the Life Span: Prevention, Treatment, and Policy Issues 138, 138 (1993); Mark B. Sobell & Linda Carter Sobell, *Controlled drinking after 25 years: How important was thegreat debate?* 90 Addiction, 1149-53 (1995).

[50] Christiane Poulin, MD, MSc & David Elliot, MD,. *Alcohol, tobacco and cannabis use among Nova Scotia adolescents: Implications for prevention and harm reduction*. 156 Canadian Medical Association Journal, 1387, 1392 (1997).

[51] *Id.* at 1387.

[52] H. Wechsler, A. Davenport, G. Dowdall, B. Moeykens, & S. Castillo, *Health and behavioral consequences of binge drinking in college: A national survey of students at 140 campuses. 272* Journal of American Medical Association, 1672-77 (1994); H. Wechsler, & T.F. Nelson, *What we have learned from the Harvard School of Public Health College Alcohol Study: Focusing attention on college student alcohol consumption and the environmental conditions that promote it*. 69 Journal of Studies on Alcohol and Drugs, 481-90 (2008).

[53] Mark B. Sobell & Linda Carter Sobell,*Treatment for problem drinkers: A public health priority*. Addictive Behaviors across the Life Span: Prevention, Treatment, and Policy Issues. 138, 149 (1993).

[54] Mark B. Sobell & Linda Carter Sobell, *Controlled drinking after 25 years: How important was thegreat debate?* 90 Addiction, 1149, 1151 (1995).

normative feedback campaigns.[55] If these efforts are unsuccessful, the client could receive more extended professional services, such as formal outpatient counseling. More intense outpatient and inpatient options may also be introduced should earlier treatments not work.[56] Subsequent interventions of increased intensity are only offered if the former, less intensive, interventions are proven ineffective.[57] Thus far, literature on heavy college drinking has largely focused on early stage prevention efforts with alcohol skill education groups[58] and normative feedback interventions.[59] However, research has paid little attention to the higher level of care, treatments available at this level, and what type of treatment to implement.

A fundamental question that lies within a stepped care approach is how it should be determined whether a treatment is working sufficiently and whether a person should move to a higher level of care. It is generally considered that changes in treatment should be made based on the client's functioning (e.g. whether a relapse has occurred).[60] Using substance use problems as an example, should there be a continued period of abstinence, it would not be needed to increase treatment dosage or to change treatment types.[61] However, if the client

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[55] Mary E. Larimer, Aaron P. Turner, Britt K. Anderson, Johnathon S. Fader, Jason R. Kilmer, Rebekka S. Palmer, Jessica M. Cronce, *Evaluating a brief alcohol intervention with fraternities*. 62 Journal of Studies on Alcohol, 370-80 (2001); G. Alan Marlatt, Jalie A. Tucker, Dennis M. Donovan, & Rudy E. Vuchinich,*Help-seeking by substance abusers: The role of harm reduction and behavioral-economic approaches to facilitation treatment entry and retention.* Beyond the therapeutic alliance: Keeping the drug-dependent individual in treatment 44, 66(1996); G. Alan Marlatt & Katie Witkiewitz, *Harm reduction approaches to alcohol use: Health promotion, prevention, and treatment*. 27 Addictive Behaviors, 867-86 (2002).

[56] *Id.*

[57] *Id.*

[58] Kinder, B. N., Pape, N. E., & Walfish, S. (1980). Drug and alcohol education programs: A review of outcome studies. *Substance Use & Misuse, 15,* 1035-54; Kivlahan, D. R., Marlatt, G. A., Fromme, K., Coppel, D. B., & Williams, E. (1990). Secondary prevention with college drinkers: Evaluation of an alcohol skills training program. *Journal of Consulting and Clinical Psychology, 58*, 805-10; Larimer, M. E., & Cronce, J. M. (2007). Identification, prevention, and treatment revisited: Individual-focused college drinking prevention strategies, 1999-2006. *Addictive Behaviors, 32*, 2439-68.

[59] G. Agostinelli, J.M. Brown, & W.M. Miller, *Effects of normative feedback on consumption among heavy drinking college students*. 25 Journal of Drug Education, 31-40 (1995); Brian Borsari, & Kate B. Carey,*Peer influences on college drinking: A review of the research.* 13 Journal of Substance Abuse, 391, 402 (2001); H. Riper, A. van Straten, M. Keuken, F. Smit, G. Schippers, & P. Cuijpers, *Curbing problem drinkers with personalized-feedback interventions: A meta-analysis.* 36 American Journal of Preventive Medicine, 247-55 (2009).

[60] Mark B. Sobell & Linda Carter Sobell, *Stepped care as a heuristic approach to the treatment of alcohol problems.* 68 Journal of Consulting and Clinical Psychology, 573, 574 (2000).

[61] *Id.*

relapses or increases substance use uptake, a change in treatment would be necessary.[62] Two types of changes have been delineated: quantitative (e.g. increasing the number of sessions) and qualitative (e.g. using a different treatment modality).[63] The determination of whether to quantitatively or qualitatively change treatment should be made on a case-by-case basis depending on whether the individual has shown some change, the individual's belief that the treatment is or is not a good match, and the individual's level of motivation.[64] Several logistical factors must also be considered, such as the availability of treatments in a particular area, whether an individual can take time off work or school (should inpatient services be recommended), and whether the home environment is supportive.[65] This paper will largely focus on qualitative changes to treatment and the options available.

When examining qualitative changes to treatment at a higher level of care than campus-wide interventions, treatment changes broadly fall into two-categories: abstinence and harm reduction interventions. Both of these treatment modalities can be used in a stepped care approach. Abstinence-focused interventions hold the goal that the key to successful treatment is complete cessation of substance use. Although different treatment modalities can differ in how they communicate abstinence, with more extreme centers having zero-tolerance policies, all such programs hold the belief that not using is the solution. Conversely, harm reduction programs focus on the reduction of the harmful consequences of addictive behaviors for both the drug consumer as well as the community in which they live.[66] Although abstinence and harm reduction treatments have different philosophies towards treatment, both are effective.[67]

Research on specific qualitative changes to treatment (e.g. changing treatment from Twelve Step Facilitation to Relapse

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62 *Id.*

63 *Id.* at 577.

64 *Id.* at 574.

65 *Id.*

66 Marlatt, *supra* note 49, at 785.

67 Sandra A. Brown, Suzette V. Glasner-Edwards, Susan R. Tate, John R. McQuaid, John Chalekian, & Eric Granholm, *Integrated Cognitive Behavioral Therapy versus Twelve-Step Facilitation therapy for substance-dependent adults with depressive disorders*. 38 Journal of Psychoactive Drugs, 449-60 (2006); Project MATCH Research Group, *Project MATCH secondary a priori hypotheses.* 92 Addiction, 1671-98 (1997); M. Sanchez-Craig, H. M. Annis, A.R. Bornet, & K.R. MacDonald, *Random assignment to abstinence and controlled drinking: Evaluation of a cognitive-behavioral program for problem drinkers*. 52 Journal of Consulting and Clinical Psychology, 390-403 (1984).

Prevention) has been scant. Although this review paper discusses several treatment options available to those with substance use issues, it is not intended to summarize comprehensive treatment manuals or list all available treatments. Instead, this paper aims to highlight the availability of several empirically validated treatment options, how they have been used, and characteristics of individuals, for whom, the treatment may be useful. This is consistent with the World Health Organization's call to offer a variety of intervention opportunities to capture the heterogeneous nature of the substance use.[68]

The following sections of this paper will discuss the goals of each treatment modality, specific treatments used, as well as general conclusions regarding their respective effectiveness. Because the current paper is not intended to summarize treatments, but rather to put various treatments within a broader context for colleges to apply a stepped care approach, the paper mainly utilized review papers, large multi-site studies with rigorous methodology, and meta-analyses that provide an overall picture of the effectiveness or efficacy of various treatments. For added detail, such as gender differences, individual papers within the reviews or meta-analyses are highlighted.

3.1.1 Abstinence-Focused Treatments

Alcoholics Anonymous (AA) is arguably the most widespread abstinence-based treatment program. It has been estimated that nearly one million Americans enter formal treatment for substance use problems annually[69] and a majority of the programs entered are twelve-step oriented programs.[70] Given the prevalence of abstinence and twelve-step based interventions, it is important to understand differences within this treatment philosophy. Overall findings and integration of this research are described in the subsequent paragraphs.

There is a plethora of research that has generally supported the effectiveness of twelve-step treatments in white, Hispanic, and Africa-American cultures with those attending weekly meetings being less

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[68] World Health Organization, *The World Health Report 2001 – Mental Health: New Understanding, New Hope*. Geneva: World Health Organization (2001).

[69] National Institute of Alcoholism and Alcohol Abuse. *National Drug and Alcoholism Treatment Unit Survey*. (DHHS Publication No. SMA 93-200). Washington, D.C.: U.S. Government Printing Office (1993).

[70] *See generally,* Robin Room, *Alcoholics Anonymous as a social movement*. Research on Alcoholics Anonymous 167-89 (1993).

likely of relapsing[71] The benefits of AA have also been replicated in women with women having more beneficial outcomes than men from AA.[72] A review of AA, Twelve-Step Facilitation, and other twelve-step based programs found that these treatments did not significantly differ in their effectiveness from comparable treatments.[73] This finding may point to a more general theme in the research that there are not significant differences between abstinence-based treatment modalities.

Project MATCH (Matching Alcoholism Treatment to Client Heterogeneity) is a significant endeavor that sought to examine differences in abstinence-based treatments as well as to determine whether there were certain client-characteristics that could be used to better match clients to treatments.[74] Project MATCH was developed by the US National Institute on Alcohol Abuse and Alcoholism (NIAAA) to understand differences in alcohol treatment outcomes among abstinence-based interventions.[75] This study is unique its ability to examine client characteristics as a predictor of substance use treatment outcomes and also to compare three programs with a goal of abstinence.[76] Client-treatment-matching is based on the idea that clients should benefit from treatment that better addresses their particular needs or deficits.[77] The three interventions compared in Project MATCH were Cognitive Behavioral Coping Skills Therapy (CBT),[78]

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[71] Robert Fiorentine, *After drug treatment: Are 12-step programs effective in maintaining abstinence?* 25 American Journal of Dug and Alcohol Abuse, 93, 96 (1999); John McKellar, Eric Stewart, & Keith Humphreys,*Alcoholics Anonymous involvement and positive alcohol-related outcomes: Cause, consequence, or just a correlate? A prospective 2-year study of 2,319 alcohol-dependent men*. 71 Journal of Consulting and Clinical Psychology, 302-08 (2003); Christine Timko, Rudolf H. Moos, John W. Finney, & Ellen G. Connell, *Gender differences in help-utilization and the 8-year course of alcohol abuse*. 97 Addiction, 877-89 (2002).

[72] Christine Timko, Rudolf H. Moos, John W. Finney, & Ellen G. Connell, *Gender differences in help-utilization and the 8-year course of alcohol abuse*. 97 Addiction, 877 (2002).

[73] M. Ferri, L. Amato, & M. Davoli, *Alcoholics Anonymous and other 12-step programmes for alcohol dependence*, http://www.thecochranelibrary.com, 1, 10 (2006).

[74] Project MATCH Research Group,*Project MATCH: Rationale and Methods for a Multisite Clinical Trial Matching Patients to Alcoholism Treatment*. 17 Alcoholism: Clinical and Experimental Research, 1130 (1993).

[75] *Id.*

[76] *Id.* at 1134.

[77] *See generally* Project MATCH Research Group, *Matching patients with alcohol disorders to treatments: Clinical implications from Project MATCH*. 7 Journal of Mental Health, 589-602 (1998).

[78] *See generally,* R.M. Kadden, K. Carroll, D.M. Donovan, N. Cooney, P. Monti, D. Abrams, R. Hester, *Cognitive-Behavioral Coping Skills Therapy Manual: A clinical research guide for therapists treating individuals with alcohol abuse and dependence,* 3 Project MATCH Monograph Series (Rockville, MD, National Institute on Alcohol Abuse and Alcoholism) (1992).

Motivational Enhancement Therapy (MET),[79] and Twelve-Step Facilitation Therapy (TSF).[80] Some of the client characteristics tested in treatment matching included addiction severity, anger, antisocial personality disorder, readiness to change, psychopathology, among several other variables[81]

All treatments examined in Project MATCH had a goal of abstinence. However, each treatment had different approaches in reaching this goal. CBT views drinking behavior as related to major problems in the person's life and argues that addressing the broad spectrum of problems will be more effective than focusing on the drinking alone.[82] The goal of CBT is to overcome skills deficits and an individual's difficulty coping with high-risk situations that often trigger a relapse.[83] Conversely, MET has a goal of eliciting the client's motivation for change by utilizing the client's own resources rather than directing a client toward abstinence.[84] This type of treatment has been referenced as a good treatment among those with ambivalence or even reluctance towards change.[85] Lastly, TSF has a goal of fostering the client's commitment to AA through readings of the AA literature and encouragement to attend AA meetings and maintain journals of AA attendance.[86]

Across each of these abstinence-based treatments, CBT, TSF, and MET, no one treatment had greater effects on overall alcohol-related outcome measures.[87] This finding is consistent with other research

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[79] *See generally* W.R. Miller, A. Zweben, C.C. DiClemente, & R.G. Rychtarik, *Motivational Enhancement Therapy Manual: A clinical research guide for therapists treating individuals with alcohol abuse and dependence, 2* Project MATCH Monograph Series (Rockville, MD, National Institute on Alcohol Abuse and Alcoholism) (1992).

[80] *See generally* J. Nowinski, S. Baker, & K. Carroll, *Twelve Step Facilitation Therapy Manual: A clinical research guide for therapists treating individuals with alcohol abuse and dependence,* Vol. 1., Project MATCH Monograph Series (Rockville, MD, National Institute on Alcohol Abuse and Alcoholism) (1992).

[81] Project MATCH Research Group, *supra* note 67, at 1130.

[82] *Id.* at 1133.

[83] *Id.*

[84] *Id.*

[85] *See generally* W.R. Miller, A. Zweben, C.C. DiClemente, & R.G. Rychtarik, *Motivational Enhancement Therapy Manual: A clinical research guide for therapists treating individuals with alcohol abuse and dependence, 2* Project MATCH Monograph Series (Rockville, MD, National Institute on Alcohol Abuse and Alcoholism) (1992).

[86] Project MATCH Research Group, *supra* note 67, at 1133.

[87] Project MATCH Research Group, *Project MATCH secondary a priori hypotheses.* 92 Addiction*,* 1671-98 (1997); Project MATCH Research Group, *Matching patients with alcohol disorders to treatments: Clinical implications from Project MATCH.* 7 Journal of Mental Health*,* 589, 594 (1998).

finding abstinence-based interventions to be equally effective.[88] Although Project MATCH examined numerous client-characteristics that might be useful in terms of matching clients to specific treatments, few differences emerged.[89] The differences for each could be summarized as follows: CBT was particularly effective for clients low in dependence criteria, which is hypothesized to occur because clients lower in dependence could make greater use of skills they were taught to cope with negative thoughts and feelings.[90] TSF was more effective for patients in aftercare programs that have higher levels of alcohol dependence and for those with social networks that support drinking, as compared to MET and CBT.[91] Lastly, outpatients high in anger had better post-treatment outcomes with MET (e.g. greater periods of abstinence, drinks per drinking day) than those in CBT.[92] Despite these differences, overall findings on drinking outcomes did not indicate any significant treatment outcome differences across MET, CBT, and TSF[93]

Collectively, abstinence-based treatments provide evidence for their effectiveness of reducing long-term substance use outcomes.[94] However, there appears to be little difference in the effectiveness between treatment modalities, which points to the viability of many interventions in a stepped care approach. The several client characteristics (e.g. level of anger, dependence severity) that were found to be useful in treatment matching can be utilized to help school administrators offer treatments that are consistent with a student's presentation, particularly if a student expresses abstinence as a goal. However, abstinence does not always appear to be the most effective option with programs, such as D.A.R.E., finding students actually

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[88] *See generally,* M. Ferri, L.Amato, & M. Davoli, *Alcoholics Anonymous and other 12-step programmes for alcohol dependence*. http://www.thecochranelibrary.com (2006); P.C. Ouimette, J.W. Finney, & R. H. Moos, *Twelve-Step and Cognitive-Behavioral Treatment for substance abuse: A comparison of treatment effectiveness*. 65 Journal of Consulting and Clinical Psychology*,* 230-40 (1997).

[89] *Id.*

[90] Project MATCH Research Group, *supra* note 67, at 1687.

[91] R. Longabaugh, P.W. Wirtz, A. Zweben, & R.L. Stout, *Network support for drinking, Alcoholics Anonymous and long-term matching effects.* 93 Addiction*,* 1313-33 (1998); Project MATCH Research Group, *supra* note 67, at 1687. *Addiction, 92*, 1671-98.

[92] *Id.* at 1689.

[93] Project MATCH Research Group, *supra* note 67, at 597. Rosenbaum, D. P., & Hanson, G. S. (1998). Assessing the effects of school-based drug education: A six-year multilevel analysis of project DARE. *Journal of Research in Crime and Delinquency, 35*, 381-412.

[94] Project MATCH Research Group, *supra* note 67, at 600.

increase use in response to an abstinence message.[75]

Through the various intervention efforts delineated, there is some evidence to support these efforts in reducing alcohol consumption. However, it is also evident that there is no "one size fits all" for alcohol problems and that there are many paths towards reducing use. Harm reduction is another treatment that can be considered when using a stepped care model and thinking about qualitative changes to treatment. Harm reduction is a relatively more recent response to abstinence-based treatments. Similar to sex education programs and accepting that sexual activity is the reality among adolescents, it has been argued that alcohol use should also be accepted and that safe and limited options (e.g. using in moderate amounts, not using depressants with stimulants) for use should be made aware.[95] This example is consistent with a harm reduction approach that focuses on reducing negative consequences of use.

3.1.2 Harm Reduction Treatments

All of the treatment approaches and policies reviewed thus far have a goal of abstinence. However, resistance from these approaches led to the bourgeoning of harm reduction. A harm reduction approach is consistent with the stages of change model and motivational interventions[96] used to treat many addictive behaviors.[97] This approach seeks to "meet people where they are" even if he or she chooses to reduce harmful patterns of use rather than committing to complete abstinence.[98]

Harm reduction originated in Europe and gained significant traction in the United States, as it emerged primarily out of frustration with narrowly defined treatment goals for dealing with problems that are highly resistant to change.[99] This treatment approach shifts the

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[95] Poulin, *supra* note 50, at 1392.

[96] C.C. DiClemente, & J.O. Prochaska, *Toward a comprehensive, transtheoretical model of change: Stages of change and addictive behavior* 2 Treating Addictive Behaviors 3-24 (1998).

[97] B. Saunders, C. Wilkinson, & M. Phillips, *The impact of a brief motivational intervention with opiate users attending a methadone programme*. 90 Addiction, 415-24 (1995).

[98] G. Alan Marlatt, & Katie Witkiewitz, *Relapse prevention for alcohol and drug problems.* 2 Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors, 1-44 (2005).

[99] R.A. Roffman, & R.S. Stephens, *Relapse prevention for cannabis abuse and Dependence* 2 Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors, 179-207 (2005).

focus away from alcohol use itself, to the harmful consequences of one's drinking behavior.[100] Such a focus is consistent with the World Health Organization's recommendation that the prevention of alcohol dependence be seen within the context of the broader goal of preventing and reducing alcohol-related problems (e.g. accidents, injuries, suicide, violence).[101] This intervention was developed out of traditional substance use treatment services that tend to take an abstinence-focused, zero-tolerance approach.[102] It has been suggested that many people who cannot or do not want to completely abstain, but who want to moderate their use, do not seek treatment because many treatment centers have a front-end requirement for abstinence to receive services[103]

Four central assumptions, principles, and values of harm reduction have been delineated: (1) Harm reduction is a public health alternative to the moral/criminal and disease models of drug use and addiction; (2) Harm reduction recognizes abstinence as an ideal outcome but accepts alternative approaches that reduce harm;[104] (3) Harm reduction has emerged primarily as a "bottom-up" approach based on addiction advocacy, rather than a "top-down" policy;[105] and (4) Harm reduction promotes low-threshold access to services as an alternative to traditional high-threshold approaches.[106] By providing a low-threshold, bottom-up approach to treatment, harm reduction aims to reduce stigmatizing attitudes towards treatment[107] by helping individuals focus on the consequences of their use rather than themselves, which they may not initially perceive as the problem.[108]

Low-threshold access to services as an alternative to high-threshold approaches (e.g. abstinence) are particularly important in colleges, where many students are surrounded by social pressures and

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100 Marlatt, *supra* note 49, at 785.

101 World Health Organization, *supra* note 48, at 93.

102 Marlatt, G. A. (1996). Harm reduction: Come as you are. *Addictive behaviors*, *21*(6), 779-78.

103 G. Alan Marlatt, A.W.Blume, & G. A. Parks, *Integrating harm reduction therapy and traditional substance abuse treatment*. 33 Journal of Psychoactive Drugs, 13, 13 (1993).

104 *See generally* Marlatt, *supra* note 49.

105 *Id.*

106 G. Alan Marlatt, *Harm reduction: Come as you are*, 21 ADDICTIVE BEHAVIORS 779, 787 (1996).

107 MARLATT ET AL, BEYOND THE THERAPEUTIC ALLIANCE: KEEPING THE DRUG-DEPENDENT INDIVIDUAL IN TREATMENT 54 (1996).

108 *Id.* at 60.

may not want to completely abstain from use, but will learn skillful ways of reducing their use amidst peer influence.[109] Low-threshold services intend to make it easier to get involved with treatment and do not require as much "buy-in" from clients who may already feel stigmatized about the prospect of treatment.[110] A main component of low-threshold approaches is that they seek to reduce the stigma associated with problems of addiction, substance abuse, and high-risk sexual practices.[111] A review of determinants of help-seeking by individuals with substance use issues found that the primary factor that motivates people to seek treatment is not the "substance use" itself, but the problematic consequences or the harmful effects of using the drug.[112] Thus, focusing on the consequences of use, rather than the specific person, may be less stigmatizing for individuals and subsequently increase the likelihood an individual seeks treatment, thereby normalizing the occurrence of receiving services.

It should be noted that, regardless of the specific harm reduction treatment modalities found in the literature, stigma reduction is inherent in harm reduction interventions.[113] Prior research on harm reduction has suggested that a harm reduction perspective normalizes high-risk behaviors and places the behaviors in the context of learned habits that are influenced by powerful reinforcers[114] Focusing on these high-risk behaviors and consequences, rather than condemning the person, has been argued as a gateway to reducing the stigma and shame surrounding substance use.[115] Incorporating harm reduction as an alternative treatment option in a stepped care approach could be one pathway towards stigma reduction.

One subset of harm reduction involves controlled drinking skills (e.g. not drinking in large and dangerous quantities).[116] Research on controlled drinking suggests low-threshold versus high-threshold

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109 *Id.* at 62.

110 Marlatt, *supra* note 49, at 787.

111 *Id.*

112 G. Alan Marlatt et al., *Help-Seeking by Substance Abusers: The Role of Harm Reduction and Behavioral-Economic Approaches To Facilitate Treatment Entry and Retention, in* BEYOND THE THERAPEUTIC ALLIANCE: KEEPING THE DRUG-DEPENDENT INDIVIDUAL IN TREATMENT 50 (L. Onken et al. eds., 1996). e.g., health, interpersonal, financial problems, etc.

113 *Id.* at 62.

114 Marlatt, *supra* note 49, at 787.

115 *Id.*

116 *Id.* at 786.

services may operate differently for different populations.[117] Specifically, findings on controlled drinking indicate: (1) recoveries of individuals who have been severely dependent on alcohol primarily involve abstinence, (2) recoveries of individuals who have not been severely dependent on alcohol primarily involve reduced drinking, and (3) the association of outcome type and dependence severity is independent of advice provided in treatment.[118] These findings are consistent with Project MATCH's results that support dependence severity as a client-characteristic involved in treatment matching.[119]

The findings in the controlled drinking literature also highlight the importance of offering different treatment options for individuals at various stages of use.[120] There are several harm reduction based interventions that can be used or acknowledged in a stepped care approach. Similar to the abstinence-based interventions outlined earlier, this paper does not aim to summarize entire treatment models, but to provide a broader understanding of each treatment's goals and effectiveness within different populations. A more comprehensive summary of various harm reduction treatments, and research supporting the effectiveness of such treatments, can be found elsewhere in the literature.[121]

Relapse Prevention (RP) is one type of harm reduction intervention. It is based on the cognitive-behavioral framework that seeks to identify high-risk situations in which an individual is vulnerable to relapse, and to use both cognitive and behavioral coping strategies to prevent future relapses in similar situations.[122] RP has been described as a prevention strategy with two specific aims: (1) to prevent an initial lapse and maintain treatment goal, and (2) provide lapse management to prevent future relapses. A meta-analysis of RP found it to be generally effective.[123] However, it was particularly

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[117] *Id.* at 782.

[118] Mark B. Sobell & Linda C. Sobell, *Controlled drinking after 25 years: how important was the great debate?*, 90 ADDICTION 1149, 1149 (1995).

[119] Project Match Research Group, *Project MATCH secondary a priori hypotheses,* 92 ADDICTION 1671, 1694 (1997).

[120] *Id.* at 1693.

[121] *See generally* Katie Witkiewitz & G. Alan Marlatt, *Overview of harm reduction treatments for alcohol problems*, 17 INT'L JOURNAL OF DRUG POLICY 285 (2006).

[122] Marlatt, G. A., & Witkiewitz, K. (2005). Relapse prevention for alcohol and drug problems. In G. A. Marlatt & D. M. Donovan (Eds.) *Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors, Second Edition* (pp. 1-44). New York, NY: Guildford.

[123] Jennifer E. Irvin et al., *Efficacy of Relapse Prevention: A Meta-Analytic Review*, 67

effective for those with alcohol or polysubstance use disorders and those who are taking adjunctive medications.[124] This meta-analysis offers two main conclusions: (1) RP is a generally effective intervention across various substances and (2) there are several moderators that may explain for whom RP is especially effective.[125] Consistent with the aim of the current review, RP is another viable treatment option that can be integrated into a stepped care model, but it may be particularly beneficial for certain types of substance use problems.[126]

Motivational Interviewing (MI) is a less standardized version of MET that blends principles of motivational psychology, client-centered therapy, and process of change; it is aimed at reducing harmful behaviors.[127] This approach is not specific to addictive behaviors, but can be used with any treatment modality as a way of eliciting change and reducing ambivalence. A meta-analysis of clinical trials using this approach found moderate effect sizes for treatments involving alcohol, drugs, as well as diet and exercise (from .25 to .57).[128] Both brief and long-term motivational interviewing approaches have been shown to be effective in reducing substance use among adolescents and young adults at three month-follow-up periods.[129] However, there have been mixed results with longer term follow-ups, with one study finding continued abstinence after a brief motivational interviewing program at 6 months[130] and another study finding no differences between intervention and control groups at 12-month.[131] Although many factors could be influencing these results, findings suggest that MI may be useful to consider when examining qualitative changes to treatment,

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JOURNAL OF CONSULTING AND CLINICAL PSYCHOLOGY 563, 563 (1999).

[124] *Id.*

[125] *Id.* at 569.

[126] *Id.*

[127] Haug, N. A., Sorensen, J. L., Gruber, V. A., & Song, Y. S. (2005). Relapse prevention for opioid dependence. In G. A. Marlatt & D. M. Donovan (Eds.) *Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors, Second Edition* (pp. 1-44). New York, NY: Guildford; Miller, W. M., & Rollnick, S. (2012). *Motivational Interviewing: Helping People Change*. Guilford: New York.

[128] Brian L. Burke et al., *The Efficacy of Motivational Interviewing: A Meta-Analysis of Controlled Clinical Trials*, 71 Journal of Consulting and Clinical Psychology 843, 843 (2003).

[129] Jim McCambridge & John Strang, *Deterioration over time in effect of Motivational Interviewing in reducing drug consumption and related risk among young people*, 100 ADDICTION 470, 471 (2005).

[130] Bill Saunders et al., *The impact of a brief motivational intervention with opiate users attending a methadone programme*, 90 ADDICTION 415, 415 (1995).

[131] McCambridge, *supra* note 129, at 470.

particularly for those who appear ambivalent towards change.

Although RP and MI are highly referenced harm reduction treatments, many other strategies are also being used, including Guided Self-Change - a brief intervention aimed at helping patients identify strengths and motivate recovery.[132] Moderation-oriented cue exposure has also been used as an effective behavioral treatment that is based on classical conditioning techniques.[133] The goal of this treatment is to expose clients to alcohol-related cues without providing the opportunity to drink, thereby extinguishing the relationship between cues and conditioned alcohol responding.[134]

Collectively, harm reduction treatment outcome research provides evidence for the effectiveness of this modality. The goal of this treatment is not simply to reduce the harmful consequences of use, but to reduce stigma by offering low-access services to individuals who are not ready to buy into an abstinence-based program.[135] Thus, students presenting as reluctant to completely abstain from at least one substance may find utility in a harm reduction message. Many treatment approaches can incorporate harm reduction goals. RP appears to be an effective treatment for individuals with alcohol and polysubstance use disorders who are taking adjunctive medications.[136] Given its focus on dealing with high risk situations that trigger use, RP may be most useful for individuals living in difficult environmental circumstances.[137] Research has also supposed the utility of MI in treating substance use disorders.[138] This treatment modality appears to be particularly effective for clients higher in ambivalence and more reluctant to change.[139] The findings across various harm reduction interventions indicate that many approaches can be incorporated into a

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[132] Mark B. Sobell & Linda Carter Sobell, *Guided Self-Change Model of Treatment for Substance Use Disorders*, 19 JOURNAL OF COGNITIVE PSYCHOTHERAPY: AN INTERNATIONAL QUARTERLY 199, 201 (2005); Linda Carter Sobell, *Bridging the Gap Between Scientists and Practitioners: The Challenge Before Us*, 27 BEHAVIOR THERAPY 297, 309 (1996).

[133] Sharon Dawe et al., *Efficacy of Moderation-Oriented Cue Exposure for Problem Drinkers: A Randomized Controlled Trial*, 70 JOURNAL OF CONSULTING AND CLINICAL PSYCHOLOGY 1045, 1045 (2002).

[134] *Id.*

[135] Nick Heather et al., *A Randomized Controlled Trial of Moderation-Oriented Cue Exposure*, 61 JOURNAL OF STUDIES ON ALCOHOL 561,561 (2000).

[136] Irvin et al., *supra* note 123, at 569.

[137] Elizabeth A. Wells et al., *Outpatient Treatment for Cocaine Abuse: A Controlled Comparison of Relapse Prevention and Twelve-Step Approaches*, 20 AM. J. DRUG ALCOHOL ABUSE 1,14 (1994).

[138] *See generally* Burke et al., *supra* note 128.

[139] *Id.* at 843.

stepped care model, particularly when examining qualitative changes towards treatment.

3.1.3 Comparing Treatment Modalities

Taken together, both abstinence and harm reduction programs offer some utility in the treatment of substance use disorders in their respective contexts. However, the exact utility of each approach depends on the individual and the context in which the treatment is prescribed. Such information would aid school administrators in determining which treatments to offer at each level of a student's use, as well as being able to tailor services to a student's preference and level of motivation. Unfortunately, few studies have directly compared abstinence and harm reduction programs.

Literature comparing abstinence-based and harm reduction programs have yielded mixed results. A recent study of veterans comparing Integrated Cognitive Behavioral Therapy (ICBT) and Twelve Step Facilitation (TSF) found that participants randomized to TSF used substances less frequently throughout the treatment period relative to those in ICBT.[140] However, those in ICBT, which included facets of RP, had more stable outcomes throughout the six-month follow-up period.[141] Other studies have found no differences in long-term outcomes between the abstinence and harm reduction goals.[142] There are several factors that may account for the discrepant findings. First, the Brown et al. study and the Sanchez-Craig et al. study examined individuals at different levels of severity (e.g. first treatment epidosde versus later treatments). Second, several of the studies included veterans with comorbid disorders.[143] Third, the studies discussed are over 20 years apart; cohort differences and more accepting thoughts about harm reduction may have changed, leading to more stable differences in the Brown et al. study. Lastly, differences in how abstinence or harm reduction goals were emphasized in the programs may not have been distinct enough to discern any treatment

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[140] Sandra A. Brown et al., *Integrated Cognitive Behavioral Therapy Versus Twelve-Step Facilitation Therapy for Substance-Dependent Adults with Depressive Disorders*, 38 JOURNAL OF PSYCHOACTIVE DRUGS 449, 457 (2006).

[141] *Id.* at 458.

[142] David W. Foy et al., *Broad-Spectrum Behavioral Treatment for Chronic Alcoholics: Effects of Training Controlled Drinking Skills*, 52 JOURNAL OF CONSULTING AND CLINICAL PSYCHOLOGY 218, 218 (1984); Wells et al., *supra* note 137, at 14.

[143] Brown et al., *supra* note 140, at 451.

differences.

It has also been argued that abstinence and harm reduction treatments can be integrated into a single treatment.[144] Furthermore, the integration of the two has been suggested as a more powerful intervention than either alone.[145] Combining the accepting, non-judgmental atmosphere of harm reduction with the added clarity of having abstinence as a long-term goal may promote patient retention better than either program separately.[146] A number of factors should be considered for this argument.[147] First, harm reduction is a valuable approach for not just the user themself, but can be used as a public health measure to protect families and the wider community from harms.[148] Secondly, few people make an immediate, once-only transition from drug use to abstinence, so it may be useful to use harm-reduction measures when people are still using.[149] Thirdly, abstinence may not be an immediately realistic goal for some users, despite their desire for complete cessation.[150] Thus, it is important to consider whether persistent failed attempts at abstinence would be more damaging and demoralizing than having some success on harm reduction goals (e.g. abstaining from using stimulants and depressants simultaneously).[151]

Given the strengths of both abstinence and harm reduction programs, both treatment philosophies can inform separate parts of the same continuum of care and,[152] in some ways, they may even be best used together.[153] Thus, it may not be that one modality is more effective, but the two used in conjunction may capture a greater portion of the population that has not yet received services. Low-threshold clients (e.g. college students who have not accepted abstinence as the goal) who have not taken action towards change may benefit the most

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144 Samuel A. MacMaster, *Harm Reduction: A New Perspective on Substance Abuse Services*, 49 SOCIAL WORK 356, 361 (2004).

145 Roy Futterman et al., *Integrating Harm Reduction and Abstinence-Based Substance Abuse Treatment in the Public Sector*, 25 SUBSTANCE ABUSE 3, 7 (2004).

146 *Id.*

147 Neil McKeganey et al., *What are drug users looking for when they contact drug services: abstinence or harm reduction?*, 11 DRUGS: EDUCATION, PREVENTION AND POLICY 423, 432 (2004).

148 *Id.*

149 *Id.*

150 *Id.* at 433.

151 *Id.*

152 MacMaster, *supra* note 144, at 361.

153 Futterman, *supra* note 145, at 7.

from a harm reduction perspective.[154] One method for using these treatment modalities in a unified approach is through a stepped-care model.[155] Taking a stepped-care approach allows clinicians and school administrators to view problems and treatment modalities on a continuum. Furthermore, providing a continuum of care and services at various levels of severity may ultimately decrease concerns about labeling and stigma, a factor related to the reticence in receiving treatment.[156]

4. Limitations of Current Research

The current review aims to integrate interventions used among those in need of a higher level of care using a stepped care model. Abstinence and harm reduction treatments both appear to effectively treat substance use disorders. Furthermore, both treatments can be used within a stepped care model and are useful alternatives to consider when examining qualitative changes to treatment when an individual is not responding. Despite this extensive review, methodological limitations across the current research still need to be addressed.

4.1 Lack of college-specific treatment outcomes

Many of the intervention studies discussed thus far have not specifically examined college substance use. Instead, many of the studies recruited samples above 18 years old and have mean ages around 40 years old. Other studies used veteran samples that are generally an older demographic. Such sample characteristics limit generalizability to college students specifically. It is plausible that some of the individuals in the studies were college students who were on a leave of absence or still in college, but given the lack of information provided, it is difficult to make definitive inferences.

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[154] MacMaster, *supra* note 144, at 361.

[155] Marlatt, G. A., Tucker, J., Donovan, D., & Vuchinich, R. (1996). Help-seeking by substance abusers: The role of harm reduction and behavioral-economic approaches to facilitation treatment entry and retention. In L. Onken & J. Blaine & J. Boren (Eds.), *Beyond the therapeutic alliance: Keeping the drug-dependent individual in treatment* (pp. 44-84). Rockville, MD: U.S. Department of Health and Human Services.

[156] Marlatt, G. A., Tucker, J., Donovan, D., & Vuchinich, R. (1996). Help-seeking by substance abusers: The role of harm reduction and behavioral-economic approaches to facilitation treatment entry and retention. In L. Onken & J. Blaine & J. Boren (Eds.), *Beyond the therapeutic alliance: Keeping the drug-dependent individual in treatment* (pp. 44-84). Rockville, MD: U.S. Department of Health and Human Services.

Given that not all colleges offer on-campus counseling services for substance use issues,[157] it could be that students are receiving services from community mental health clinics or local treatment centers that cater to a larger population.

4.2 Gender differences

Several of the studies reviewed across treatment modality included either a predominantly male sample or a male-only sample.[158] Although males tend to drink more and experience more consequences, females are not exempt from alcoholism and alcohol-related problems.[159] Despite the relative lack of literature on female substance use treatment outcome, there is data to suggest females benefit just as much as men from abstinence programs.[160] Research that more thoroughly examines gender differences in both abstinence and harm reduction treatment outcomes may help school administrators to better target interventions towards students.

4.3 Stigma and Treatment Outcomes

Lastly, this paper hypothesizes that stigma may be reduced by increasing awareness of treatment options and increasing the number of students receiving treatment; however, this is an empirical question and needs to be tested in further research. There are many pathways that would support this hypothesis. It could be that stigma would be reduced by simply normalizing the occurrence of treatment with more people finding a treatment that fits with their needs (e.g. harm reduction vs. abstinence). It could also be that the more students receive treatment, the less harmful consequences they experience as a result of alcohol use. This area of research requires further examination to fully understand what mechanism would be implicated in mental health stigma reduction.

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[157] Henry Wechsler et al., *Colleges Respond to Student Binge Drinking: Reducing Student Demand or Limiting Access*, 52 JOURNAL OF AMERICAN COLLEGE HEALTH 159, 161 (2004).

[158] Kathleen T. Brady & Carrie L. Randall, *Gender Differences in Substance Use Disorders*, 22 ADDICTIVE DISORDERS 241, 241 (1999).

[159] *Id.* at 249.

[160] Christine Timko et al., *Gender differences in help-utilization and the 8-year course of alcohol abuse*, 97 ADDICTION 877, 887 (2002).

5. Conclusions

Despite several limitations to the literature, it is clear that college heavy drinking behaviors are a complex phenomenon that can be treated from a number of different perspectives. Given the continued emphasis on reducing heavy college drinking, and lack of a unified methodology to deal with the issue, a review paper putting the problem in a broader context is necessary to assist schools in handling substance use issues. This article sought to unify diverse theoretical and empirical approaches to dealing with college substance use through the use of a stepped care model. Although prior studies have examined the association between college drinking, school intervention policies, and stigma separately, no study, to our knowledge, has examined how the literature on mental health stigma and intervention efforts jointly impacts college-drinking behaviors and the stigma one experiences.

The present review suggests that there is no "one-size fits all" intervention effort that will work across campuses or across individuals. Colleges and universities must acknowledge that college substance use is a heterogeneous phenomenon that cannot be combatted with a single prevention or intervention approach. Instead, the goal is to provide a range of options (either on campus or referrals off campus), available at various stages of a student's substance use, to prevent either onset or progression of use. There is a particular need for colleges to focus on students in need of a higher level of care, who do not respond to campus-wide interventions, such as normative feedback.[161] Various treatment options can be considered at this higher level of care, but these interventions broadly fall into two categories: abstinence and harm reduction.[162] Research has previously tried to juxtapose these services. However, the present review suggests that both harm reduction and abstinence can be integrated into a stepped care model where both can work for different individuals depending on the client's preferences and beliefs about abstinence. Taking this approach not only provides more options, which is consistent with the World Health Organization's[163] call for a diverse set of treatment options, but is also hypothesized to reduce stigma by making more treatments, particularly harm reduction interventions, known and

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161 Wechsler et al., *supra* note 157, at 167.
162 MacMaster, *supra* note 144, at 356.
163 World Health Organization, World Health Report xvi (2001).

available. The reduction of mental health stigma is an important area for treatment to address, as those with addiction are perceived as more harmful than other types of mental illness, and less than a quarter of those who need substance use treatment have been reported to actually seek treatment.[164]

Given that numerous treatments are effective in reducing substance use, and that certain client-characteristics may impact the effectiveness of treatment, the current paper argues that school counselors and administrators should assess a variety of factors relating to one's substance use, particularly one's readiness to quit and one's thoughts regarding abstinence. There is no approach that will work with all students, but administrators can present students with a diverse set of options and let them choose the one that best represents their current state and goals. This line of research is a step toward understanding what types of interventions should be implemented at each step in a continuum of care model. It is crucial for researchers and clinicians alike to recognize the heterogeneous nature of substance use, and that it is not about finding the one treatment that works for all users. It is about having an arsenal of prevention and intervention options that can be implemented at various stages of one's use.

[164] Carlos Blanco et al., *Mental Health of College Students and Their Non-College-Attending Peers*, 65 Arch. Gen. Psychiatry 1429, 1429 (2008).

THE LIMITED PROVISION OF MENTAL HEALTH SERVICES AT COMMUNITY COLLEGES: OBSTACLES, INITIATIVES, AND OPPORTUNITIES FOR CHANGE

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Introduction

One out of every four college students suffers from a mental illness and these numbers are on the rise.[1] According to the 2014 National Survey of College Counseling Centers, 94% of college counselors report growing numbers of undergraduate students with severe psychological problems.[2] Despite the fact that college students require mental health services, they frequently encounter social, cultural, and institutional barriers to obtaining these services.[3] While 79% of college students rank mental health services as extremely important, 75% don't receive help.[4] These statistics cannot be taken lightly, given the fact that suicide is one of the leading causes of death in the United States among young people between the ages of 15 and 24.[5]

Students enrolled in community colleges face particular challenges. Community college students represent about half of all undergraduate students and account for a much higher percentage of low income and minority populations.[6] Nearly half of all minority undergraduate

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[1] Michael Kerr, *Depression and College Students*, HEALTHLINE (Mar. 29, 2012), http://www.healthline.com/health/depression/college-students.

[2] ROBERT P. GALLAGHER, NATIONAL SURVEY OF COLLEGE COUNSELING CENTERS 2014, AM. COLL. COUNSELING ASS'N 1, 5 (2014), http://d-scholarship.pitt.edu/28178/1/survey_2014.pdf. It was only in the last two years that this nationally recognized survey began to include two-year community colleges.

[3] COLLEGE STUDENTS SPEAK: A SURVEY REPORT ON MENTAL HEALTH, NAT'L ALLIANCE ON MENTAL HEALTH 1, 15 (2012), http://www2.nami.org/Content/NavigationMenu/Find_Support/NAMI_on_Campus1/NAMI_Survey_ on_College_Students/collegereport.pdf. [hereinafter NAMI, COLLEGE STUDENTS SPEAK]. Survey respondents were also asked how important it is that their colleges offer various mental health awareness activities. A majority of students (79%) stressed the importance of offering mental health training for faculty and staff and ranked it as the most important awareness activity colleges can provide. *Id.* at 10.

[4] Kerr, *supra* note 1; NAMI, COLLEGE STUDENTS SPEAK, *supra* note 3, at 10.

[5] *Id.*

[6] CHRISTOPHER C. MULLIN, WHY ACCESS MATTERS: THE COMMUNITY COLLEGE STUDENT BODY, AM. ASS'N OF CMTY. COLL. 4 (Feb. 2012)

students, and more than 40% of undergraduate students living in poverty, are enrolled in community colleges.[7] There has also been a recent trend toward higher numbers of traditional students aged 18-24 enrolling at community colleges.[8] Despite this marked increase in enrollment among both traditional and non-traditional students at community colleges, community college counseling centers have proportionally fewer resources than their four-year college counterparts.[9] For example, less than 13% of community colleges provide psychiatric services for students, while 58% of four-year colleges and universities provide such services.[10]

This note discusses the mental health needs of community college students, looking specifically at the mental health risk factors associated with the community college student population and the social and institutional barriers preventing these students from obtaining needed services. It focuses particularly on the community college systems in California and Virginia, two states displaying dramatically different levels of commitment to mental health services on campus (with California on one end of the spectrum with its progressive practices and Virginia on the other end of the spectrum).[11] The goal of this note is to increase awareness about the mental health needs of community college students, to investigate how these needs are being ignored, and to propose new approaches that community colleges might take in order to ensure access to mental health services for their student populations.[12]

The first part of this note looks at mental health issues among college students generally, including the prevalence of mental health is-

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http://www.aacc.nche.edu/Publications/Briefs/Documents/PB_AccessMatters_BW.pdf.

[7] *Id.*

[8] *See id.* at 7.

[9] Doug Lederman, *Community College Counseling Gains*, INSIDE HIGHER ED (June 18, 2013), https://www.insidehighered.com/news/2013/06/18/survey-shows-growth-counseling-services-2-year-colleges.

[10] J. Chamberlin, *Mental health services remain scarce at community colleges*, 43 UPFRONT, AM. PSYCH. ASS'N at 11 (2012), http://www.apa.org/monitor/2012/04/community-colleges.aspx.

[11] *See infra*, Part IV.

[12] This note touches only tangentially upon the issue of why the mental health needs of community college students are being ignored, but this question is ripe for future research. My own research suggests that the mental health needs of community college students are being disregarded, at least in part, for economic reasons. *See* generally Allie Grasgreen, *Too Many Hats?,* INSIDE HIGHER ED (Jan. 19, 2012), https://www.insidehighered.com/news/2012/01/19/community-college-counselors-face-challenges-survey-shows.

sues and personal obstacles and institutional barriers to seeking help. Part II discusses the origins and evolving role of community colleges. It examines the shifting demographic at community colleges and the mental health risk factors associated with the community college student population. Part III compares the provision of mental health services at two-year institutions and four-year institutions. Part IV comprises two case studies, which examine the community college systems in Virginia and California, respectively. Part V discusses how community colleges might better facilitate the provision of mental health services going forward.

Part I: The Mental Health of College Students in the United States

A. Prevalence of Mental Health Issues on College Campuses

College students began exhibiting an increased need for mental health services beginning in the mid 1990's – a trend which has continued to grow in the past decade.[13] According to the 2014 National Survey of College Counseling Centers, 94% of college counseling center directors report that the number of students with severe psychological problems continues to grow.[14] Additionally, 86% of directors report a steady increase in the number of students arriving already on psychiatric medications.[15] One in four adults between the ages of 18 and 24 has a diagnosable mental illness.[16] And 64% of young adults who have withdrawn from college are not attending because of a mental health reason, with depression, bipolar disorder, and posttraumatic stress representing the most common diagnoses.[17] More than 45% of students who left college for mental health reasons did not access mental health services or supports.[18] And the demand for mental health services is increasing.[19]

Scholars attribute the rise in mental health problems, and the increased willingness among students to seek services, to a variety of

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[13] *The State of Mental Health on College Campuses: A Growing Crisis*, AM. PSYCH. ASS'N, http://www.apa.org/about/gr/education/news/2011/college-campuses.aspx.

[14] GALLAGHER, *supra* note 2, at 5.

[15] *Id.*

[16] *Mental Health By the Numbers*, NAT'L ALLIANCE ON MENTAL ILLNESS, http://www.nami.org/Learn-More/Mental-Health-By-the-Numbers (last visited Oct. 15, 2016).

[17] NAMI, COLLEGE STUDENTS SPEAK, *supra* note 3, at 8.

[18] *Id.*

[19] GALLAGHER, *supra* note 2, at 5.

factors. These include factors such as divorce, family dysfunction, and early experimentation with drugs, alcohol, and sex; the changing demographic of college students; and, a greater acceptance among the current generation of mental health treatment.[20] Additionally, effective new psychiatric drugs have made it possible for some students to attend school who might have been otherwise unable to do so.[21]

In addition to these factors, college represents a time of transition, with many students living away from their parents for the first time in their lives and in some cases confronting newly developing mental health issues. It is in between the ages of 18 and 24 (the age of most college students), that severe psychiatric disorders, including, bipolar disorder and schizophrenia typically manifest in an individual.[22] In fact, 75% of lifetime cases of mental health conditions begin by age 24.[23] Mental health disorders are pervasive among college students across the country and can have serious, and in some cases fatal, outcomes, when not properly treated.[24] Suicide remains a leading cause of death among college students in the United States, with about 1,088 students dying by suicide every year.[25] A high percentage of college students suffering from psychiatric disorders are not treated. For example, fewer than half of students with mood disorders and 20% of students with anxiety disorders receive treatment.[26]

Additionally, studies show that those who are most at risk for suicide have low rates of utilizing mental health services on campus.[27] It

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[20] Martha Anne Kitzrow, *The Mental Health Needs of Today's College Students: Challenges and Recommendations*, 41 NASPA J. 167, 170-71, (2003), http://isites.harvard.edu/fs/docs/icb.topic920416.files/mental%20health-%20counseling-1.pdf.

[21] *Id.* at 171.

[22] ILL. DEP'T OF PUB. HEALTH, SUICIDE PREVENTION: SUICIDE AND COLLEGE STUDENTS 2, http://www.dph.illinois.gov/sites/default/files/publications/suicide-ncollege-students-050216.pdf.

[23] MENTAL HEALTH FACTS CHILDREN & TEENS, NAT'L ALLIANCE ON MENTAL ILLNESS (NAMI), https://www.nami.org/getattachment/Learn-More/Mental-Health-by-the-Numbers/childrenmhfacts.pdf.

[24] *See generally id.*

[25] *See* ILL. DEP'T OF PUB. HEALTH, INJURY PREVENTION: SUICIDE AND COLLEGE STUDENTS 1 (2011), http://www.lutheransuicideprevention.org/docs/Suicide%20and%20College%20Students%20-%20February%202011.pdf.

[26] Justin Hunt, et. al., *Mental Health Problems and Help-Seeking Behavior Among College Students*, 46 J. OF ADOLESCENT HEALTH 3, 6 (2013), http://www.jahonline.org/article/S1054-139X(09)00340-1/pdf.

[27] Ann P. Haas, *Detecting and Engaging At-Risk Students*, 17 WASH. & LEE J. CIVIL RTS. & SOC. JUST. 79, 81 (2010), http://scholarlycommons.law.wlu.edu/cgi/viewcontent.cgi?article=1271&context=crsj.

is important to treat mental health problems without delay because mental health needs can seriously impair academic performance, retention, and graduation rates.[28] According to a 2011 American College Health Association report, students cite depression as one of the top impediments to academic performance.[29] Specifically, students with higher levels of psychological stress tend to have higher test anxiety and less effective time management skills.[30]

College represents a unique time where, at least for many students, students' lives are temporarily contained with the "single integrated setting" of a college campus.[31] Mental health experts suggest that the infrastructure of campus might provide a protective network of supports and services for students suffering from mental health problems.[32] A recent article in the Journal of Adolescent Health suggests, "mental health among college students represents not only a growing concern, but also an opportunity, because of the number of people who could be reached during an important period in their life."[33] Addressing student mental health problems is not only pertinent to the academic and social success of students during college. It also plays an important role in preparing students to transition into the general population as adults. Mental health in young adulthood is associated with substance abuse, unemployment, and other socially undesirable outcomes later in life, which ultimately impact the welfare and functionality of society.[34]

B. Personal Obstacles to Seeking Mental Health Services

Students are often hesitant to seek the mental health services they need because of "internal obstacles," or private considerations that make it less likely that a student will seek services, even if he or she is not prevented from doing so from some external force or institutional barrier. Internal obstacles can play as significant a role as institutional

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[28] Kitzrow, *supra* note 20, at 171.

[29] *Id.*

[30] *Id.* at 169-170.

[31] Hunt, *supra* note 26, at 6.

[32] SUICIDE PREVENTION: SUICIDE AND COLLEGE STUDENTS*, supra* note 22, at 2-3.

[33] Hunt, *supra* note 26, at 6.

[34] Daniel Eisenberg, et al., *Help-Seeking and Access to Mental Health Care in a University Student Population*, 45 MED. CARE 594, 594 (2007), https://www.researchgate.net/publication/6266227_Help-Seeking_and_Access_to_Mental_Health_Care_in_a_University_Student_Population.

barriers in preventing students from seeking services.[35] Some of the most pervasive types of internal obstacles include: negative attitudes about mental health treatment; unwillingness to trust mental health providers; cultural, racial, and religious factors; and finally, denial or inability to perceive a problem.

Many students have negative attitudes about seeking mental health treatment.[36] According to a survey by the National Alliance on Mental Illness (NAMI), the number one reason why students do not disclose their mental health issues is fear or concern about the impact disclosing this information will have on how students, faculty, and staff perceive them (even within mental health degree programs).[37] Students are fearful of the social stigma that they associate with mental illness and of being outcast by their peers. For some students, hostility toward mental health treatment stems from cultural norms that equate treatment with moral or emotional weakness.[38]

Students might also avoid seeking helping because they fear that they will be retaliated against.[39] This fear is not ungrounded given that schools have taken retaliatory actions in response to student disclosures.[40] For example, some schools have enacted involuntary removal or mandatory leave of absence policies, designed to protect them against lawsuits stemming from student suicides.[41] Thus, a student might avoid seeking mental health services out of fear of jeopardizing his or her academic career.[42]

Factors such as race, ethnicity, and religion can also impact whether a student will seek services. Some Asian cultures view psychological problems as a weakness and look down upon individuals

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[35] I use the term institutional barriers to refer to external barriers outside of the student's control, such as a school not providing mental health services.

[36] Haas, *supra* note 27, at 81-82.

[37] NAMI, COLLEGE STUDENTS SPEAK, *supra* note 3, at 9.

[38] Haas, *supra* note 27, at 82.

[39] *Id.*

[40] *Id.*

[41] *Id.*

[42] A recent article in Newsweek tells the story of Dan, a student had Princeton, who was evicted from his dorm room and banned from campus, when he went to the student health center for help after overdosing on antidepressants. The article calls attention to the way in which mental health issues are treated as opposed to other health problems that students encounter: in many cases students are effectively punished for seeking help. Many colleges are simply unequipped to accommodate mental disabilities in the way that they accommodate physical disabilities. Katie Baker, *How Colleges Flunk Mental Health*, NEWSWEEK (Feb 11, 2014, 11:13 AM), http://www.newsweek.com/2014/02/14/how-colleges-flunk-mental-health-245492.html.

who seek professional services.[43] In some Hispanic communities, individuals are encouraged to reach out to family members or religious leaders, instead of professionals outside of the family or community.[44] Recent scholarship also documents the stigma of mental illness among the Muslim community.[45]

Additionally, minority groups might perceive the mental health services offered at most colleges and universities as unrelated to their needs. More scholarship needs to be conducted that looks at the counseling utilization trends of minority students, but it is clear that counseling centers are not paying enough attention to the needs of minority students.

A study conducted by the Counseling & Mental Health Center at the University Of Texas at Austin assessed counseling utilization among different ethnic groups.[46] The study found that Caucasians attended the greatest number of counseling sessions, while Hispanics attended the fewest number.[47] The study also found that Asian Americans displayed the greatest amount of distress at intake while Caucasians exhibited the least amount of distress.[48] The study also confirmed the trend that minority students are less likely to attend follow up sessions.[49] The study found that minority students might have greater difficulty acclimating to university campuses because of social alienation and/or lack of social support and that racism and hostile environments might cause more stress in the lives of ethnic minority students.[50] Notably, the study suggested that "counselors untrained in culturally sensitive therapy models, a dearth of bilingual counselors, few counselors with similar ethnic/racial backgrounds, and a lack of cultural sensitivity may lead minorities to feel misunderstood by therapists."[51]

Finally, denial can be a strong internal obstacle, especially when

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[43] *Id.* at 4.

[44] *Id.* at 4-5.

[45] Ayse Ciftci et al., *Mental Health Stigma in the Muslim Community*, J. OF MUSLIM MENTAL HEALTH 17, 17 (2013), http://quod.lib.umich.edu/cgi/p/pod/dod-idx/mental-health-stigma-in-the-muslim-community.pdf?c=jmmh;idno=10381607.0007.102.

[46] *See id.*

[47] *Id.* at 16.

[48] *Id.*

[49] *Id.*

[50] *Id.*

[51] Lisa K. Kearney, et al., *Counseling Utilization by Ethnic Minority Students: A Research Report of the Research Consortium of Counseling and Psychological Services in Higher Education*, U. OF TEX. AT AUSTIN 1, 4 (2003), http://cmhc.utexas.edu/pdf/ethnicmin.pdf.

combined with other factors such as lack of time, self-medication with drugs and alcohol, and lack of prodding from parents or other authority figures.[52] Denial can be subtle, and many students who do not perceive a need may be in denial.[53] Alternatively, individuals might not perceive that they have a need for mental health services.[54]

In a 2007 study examining help seeking behaviors among students attending a large public university, researchers from the University of Michigan School of Public Health found that out of students who tested positive for depression or anxiety but did not seek services, about half believed that stress was a normal part of college/graduate school or failed to perceived a need for services, and about one third believed that their problem would get better by itself.[55]

Thus, students potentially encounter a variety of internal obstacles to seeking help, even before they confront the institutional barriers that might prevent them from obtaining needed services.

C. Institutional Barriers to Seeking Needed Mental Health Services

Many students, including students at most community colleges, are denied the opportunity to access mental health services in the first place. This section will discuss several situations in which students are either denied services or effectively barred from such services. Specifically, it discusses situations in which students receive no accommodation or limited accommodation; where students are referred for services that they cannot afford; and where students receive inadequate accommodation.

The most significant barrier a student can face is the absence of mental health services and supports on campus, or services that are so difficult to access that they are effectively unavailable. In a recent survey by the National Alliance on Mental Illness (NAMI), some students indicated that they did not access mental health services because there were no services or supports available or there was a poor referral sys-

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[52] *See* Haas, *supra* note 27, at 81-82.

[53] *See* John M. Grohol, *Denial is a Powerful Impediment to Treatment*, PSYCHCENTRAL, http://psychcentral.com/lib/denial-is-a-powerful-impediment-to-treatment/ (last visited Oct. 15, 2016).

[54] Eisenberg, *supra* note 34, at 600.

[55] *Id.* at 598.

tem for mental health services and supports.[56] It is important that students are made aware that services exist and told how to access them– 24% of students surveyed listed lack of information as a barrier to accessing services.[57]

The absence of mental health services is rare at traditional four-year institutions, which almost always provide some kind of free mental health counseling services, either as part of the student health center or as part of an independent counseling center.[58] These services are usually funded by student fees and provided without any additional fees from students at the time of service.[59] Nonetheless, four-year institutions often impose a cap or limit on mental health services, often by limiting the number of visits.[60] Additionally, counseling centers at four-year institutions often lack the resources to properly treat students with more serious psychiatric problems.[61]

Many community colleges, in contrast to their four-year counterparts, fail to provide even basic mental health services.[62] An even smaller number of community colleges provide more advanced psychiatric services.[63] It is common at community colleges for counselors to only provide career counseling services, or more general counseling services.[64] Where students are unable to access needed mental health services on campus, financial barriers might prevent them from getting more specialized services from off campus providers.[65] This is espe-

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[56] NAMI, COLLEGE STUDENTS SPEAK, *supra* note 3, at 15.

[57] *Id.*

[58] AN AUDIT OF MENTAL HEALTH CARE AT U.S. COLLEGES AND UNIVERSITIES: FOCUS ON ANXIETY DISORDERS, ANXIETY DISORDERS ASS'N OF AM. 1, 4 (2007), http://www.adaa.org/sites/default/files/FINALCollegeReport.pdf (hereinafter ANXIETY DISORDER ASSOCIATION OF AMERICA); *see also* Eisenberg, *supra* note 34, at 594.

[59] GALLAGHER, *supra* note 2, at 4.

[60] *Id.*

[61] *See id.* at 5-6; Amy Karon, et al., *Gaps Persist in Campus Mental Health Services*, WISCONSINWATCH (Feb. 5, 2012), http://wisconsinwatch.org/2012/02/gaps-persist-in-campus-mental-health-services/.

[62] *See,* for example, Richard Bonnie's study, discussed below in the Virginia case study, finding that the official policy of the Virginia Community College System is that they do not provide mental health services. RICHARD BONNIE, ET AL., VIRGINIA COLLEGE MENTAL HEALTH STUDY PREPARED FOR THE JOINT COMMISSION ON HEALTH CARE GENERAL ASSEMBLY OF THE COMMONWEALTH OF VIRGINIA 1, 33 (Nov. 2011), https://www.law.virginia.edu/pdf/news/study_report_nov2011.pdf.

[63] Daniel Eisenberg, *Here's Another Reason Why Many Community College Students Do Not Get Their Degree,* HIGHER ED JOBS (Mar. 22, 2016), https://www.higheredjobs.com/articles/articleDisplay.cfm?ID=853.

[64] *Id.*

[65] *See id.*

cially true for the community college population, which includes a greater percentage of uninsured students.[66] Students might also avoid seeking treatment off campus because they lack transportation or are worried that they will have to tell someone where they are going.[67]

Finally, mental health services are only effective to the extent that they actually help students. Many students are not properly treated because the mental health services offered at their school's facility are inadequate or the delivery method is flawed.[68] In a 2012 survey by the National Alliance on Mental Illness (NAMI), students frequently complained that the providers at their institution were inexperienced (college student workers as opposed to mental health professionals); that there was a high rate of staff turnover that disrupted care; or that their institution did not have sufficient staff.[69] A related problem is whether counseling professionals are trained to deal with a diverse student population, and to provide culturally sensitive services.

Even where the mental health services offered by a counseling center are excellent, the logistics of a counseling center might pose a problem. According to the 2012 NAMI Survey, students indicated that the location of the mental health center, the hours of service, and the average wait time, can all serve as barriers to service.[70] As an increasing percentage of colleges and universities take action to respond to the growing mental health needs of college students, counselors, administrators, and other key staff members, must understand the personal and institutional barriers that might stand in the way of students seeking services.

Providing students with more information and creating a dialogue on campus might serve to break down some barriers. More stubborn barriers might be overcome with careful planning and administrative support (for example paying attention to the location of a mental health center and training staff to be sensitive to cultural and ethnic differences). This next section looks more closely at community colleges, specifically the evolving role of community colleges in promoting access to education, the changing demographic of community colleges,

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[66] Elizabeth Redden, *Among the Uninsured: 1.7 Million College Students*, INSIDE HIGHER ED (Mar. 31, 2008), https://www.insidehighered.com/news/2008/03/31/insurance.

[67] NAMI, COLLEGE STUDENTS SPEAK, *supra* note 3, at 15-16. College students identified "transportation to treatment" as a key mental health service.

[68] *See id.* at 15.

[69] *Id.* at 15-16.

[70] *Id.*

and the unique obstacles that prevent community college students from obtaining mental health services.

Part II: Community Colleges

Community colleges are increasingly being recognized for the important role they play in the lives of students, as well as their larger communities and the country as a whole.[71] According to a recent study by the American Association of Community Colleges, 71% of the American public believes that it is "sometimes better" to start at a community college rather than a four year college.[72] The study also finds that students who start at a community college are just as likely to earn a bachelor's degree after transferring to a four-year college as students who started at a four-year college.[73]

This section discusses the limited provision of mental health services at community colleges, as opposed to their four-year counterparts.

A. Historical Role of Community Colleges

As of the 2013-2014 academic year, 46% of all undergraduates were enrolled in two-year programs at community colleges.[74] This represents 7.4 million students attending a for-credit program, with 4.5 million attending part-time and 2.9 million attending full-time.[75] While enrollment at public four-year colleges and universities roughly doubled from 1965 to 1999, enrollment at public community colleges increased about fivefold.[76] This trend will likely continue given that studies show that traditional four-year colleges are increasingly priced out of the budgets of middle class families.[77] Significantly, 22% of college students from families making more than $100,000 attend community

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[71] MULLIN, *supra* note 6, at 4-5.

[72] *Id.* at 5.

[73] *Id.*

[74] 2015 FACT SHEET, AM. ASS'N OF CMTY. COLL. (Jan. 2015), http://www.aacc.nche.edu/AboutCC/Documents/FactSheet2015.pdf.

[75] *Id.*

[76] HENRY KASPER, THE CHANGING ROLE OF COMMUNITY COLLEGE, OCCUPAT'L OUTLOOK Q. 14, 14 (2002), http://www.bls.gov/careeroutlook/2002/winter/art02.pdf.

[77] SANDY BAUM, ET AL., TRENDS IN COMMUNITY COLLEGE EDUCATION: ENROLLMENT, PRICES, STUDENT AID, AND DEBT LEVELS, COLLEGEBOARD ADVOCACY & POL. CTR. 1 (2011), https://trends.collegeboard.org/sites/default/files/trends-2011-community-colleges-ed-enrollment-debt-brief.pdf.

colleges.[78]

Access to education has changed dramatically over the course of the 20th century. Only 15% of Americans were enrolled in an institution for higher education in 1953 and by 1969, this number had doubled to 30%.[79] As of 2013, 17.5 million students were enrolled in undergraduate institutions.[80] Community colleges have played an important historical role in expanding access to education for minority populations, low-income individuals, and women.[81] Today, community colleges play an invaluable role in educating about half of all undergraduate students nationwide.[82]

B. Shifting Demographic

Community colleges are undergoing dramatic shifts in their student body demographic. The community college student population becomes younger each year, with more traditional aged students attending, as well as students under the age of 18.[83] In fact, students aged 18-24 now represent the majority of students at community colleges, albeit by a slim margin.[84] This is significant because, as discussed earlier, the onset of most mental illnesses occurs in individuals between the ages of 18 and 24.[85]

The community college student population is not only becoming younger, but there appears to be a growing "social and economic divide between two and four-year colleges."[86] Specifically, the student body at community colleges is also growing poorer and more diverse. While more upper-middle class students are attending community col-

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[78] MULLIN, *supra* note 6, at 5.

[79] *Id.*

[80] *Fast Facts*, NAT'L CTR FOR ED. STATS, U.S. DEP'T OF ED. http://nces.ed.gov/fastfacts/display.asp?id=98 (last visited Oct. 20, 2016).

[81] *See* Robert W. Franco, *The Civic Role of Community Colleges: Preparing Students for the Work of Democracy*, 6 J. OF PUB. AFFAIRS 119, *passim* (2002), http://www.compact.org/wp-content/uploads/resources/downloads/CCivic_role-final.pdf.

[82] *Community Colleges Past to Present*, AM ASSOC. OF CMTY. COLL., http://www.aacc.nche.edu/AboutCC/history/Pages/pasttopresent.aspx (last visited Nov. 2, 2016).

[83] James Orbesen, *Students at Community Colleges are Getting Younger and Younger*, THE ATLANTIC, (Sept. 30, 2013) http://www.theatlantic.com/education/archive/2013/09/students-at-community-colleges-are-getting-younger-and-younger/280030/.

[84] *Id.*

[85] MENTAL HEALTH FACTS CHILDREN & TEENS, *supra* note 23.

[86] Richard Kahlenberg, *Demographic Change in Community Colleges*, THE CHRONICLE OF HIGHER ED. (Mar. 9 2012), http://chronicle.com/blogs/innovations/demographic-change-in-community-colleges/31882.

leges than in the past, an even higher percentage of low-income students are enrolling.[87] In 2014 community colleges provided education to more than 40% of all undergraduate students living in poverty and approximately half of all minority undergraduate students.[88] Community college students are more likely to be employed or supporting a family or children than other students. 84% of community college students work and 60% of those students work more than 20 hours a week.[89] 17% of community college students are single parents.[90] This is significant because working more than 20 hours per a week is a risk factor for not finishing school.[91]

The number of minority and ethnic students attending community colleges is also growing dramatically. According to 2013 data from the American Association of Community Colleges, 57% of all Hispanic undergraduate students, 52% of all African American undergraduate students, 61% of all Native American undergraduate students, and 43% of all Asian/Pacific Islander undergraduate students, attended community colleges.[92] As discussed earlier, studies show that minority students might require mental health services even more than their non-minority counterparts. But, minority students are less likely to utilize mental health services, and where they do engage such services, they are less likely to return after their first visit.[93]

While this section is concerned primarily with the mental health risk factors associated with recent trends in the community college student demographic, it is also relevant to comment on the structure of community colleges. Community colleges largely cater to commuter students (although about 25% of community colleges have more traditional campuses featuring on campus housing), as opposed to four-year institutions, which usually provide student dorms or campus housing.[94] As a result of this structure, community college students lack the protective network of services and supports often available to residential students.[95] Despite the pressing need for mental health services among

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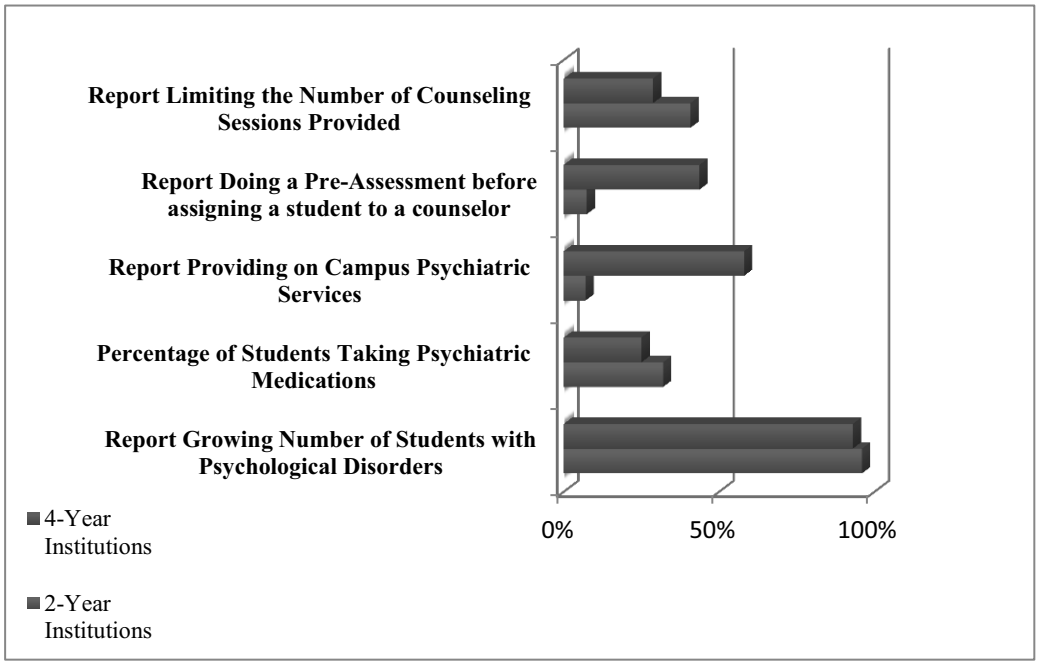
87 *Id.*
88 MULLIN, *supra* note 6, at 4.
89 *Id.* at 7.
90 *Id.*
91 *Id.*
92 *2015 FACT SHEET, supra* note 74.
93 Kearney, *supra* note 51, at 16.
94 2015 FACT SHEET, *supra* note 74.
95 Hunt, *supra* note 26, at 6.

community college students, many two-year institutions fail to provide even basic mental health services. The next section directly compares the provision of mental health services at community colleges with those at four-year institutions.

Part III: Comparison of Mental Health Services at Two-year and Four-year Institutions

There are marked differences in the provision of mental health services at two-year colleges and four-year colleges.[96] Based on the limited data available comparing the two types of institutions, it is clear that despite the fact that community colleges and four-year colleges are encountering an almost identical proportion of students with psychological problems, community colleges have proportionally fewer resources.[97]

Actual Provision of Services[98]



[96] *See* GALLAGHER, *supra* note 2.

[97] *Id.* at 23.

[98] *Id.* Original Graph based upon data from the 2014 National Survey of College Counseling Centers.

The 2014 National Survey of College Counseling Directors represents one of the few resources that directly compares the provision of mental health services at community colleges with traditional four-year colleges.[99] The survey is broken into two parts: the first part compares schools based on size and the second part compares 2-year and 4-year colleges.[100] The survey overwhelmingly shows that even as enrollments at community colleges have grown, community college counseling centers continue to have proportionally fewer resources than four-year institutions.[101] It also highlights fundamental differences between the ways in which counseling centers operate at 2-year colleges versus 4-year colleges.[102] The survey paints a startling portrait of the current state of mental health on college campuses, including 2-year colleges. Almost 96% of 2-year colleges and 93% of four-year colleges indicate that a growing number of students are arriving at their centers with serious psychological problems.[103] Additionally, college counseling centers are reporting a growing number of students arriving on campus already on psychiatric medication.[104]

Yet, according to the National Survey, only 7% of community colleges provide on-campus psychiatric services, as opposed to 58% of 4-year schools.[105] This distressing statistic is made worse by the fact that 80% of responding community college counseling centers indicate that they maintain the right to refuse treatment to a student whose problems are beyond the capabilities of center staff.[106] In other words, those students most in need might be turned away.

Approximately 7% of 2-year colleges do a pre-assessment before assigning a student to a counselor, as opposed to approximately 44% of 4-year colleges.[107] Additionally, virtually none of the community colleges surveyed used specialized intake counselors.[108] This is significant because in order for counseling to be effective, it must be tailored to meet the needs of specific students.[109] Minority groups, for example,

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99 *See* GALLAGHER, *supra* note 2.
100 *See Id.*
101 *See Id.*
102 *See Id.*
103 GALLAGHER, *supra* note 2, at 23.
104 *Id.*
105 *Id.* at 5.
106 *Id.* at 18.
107 *Id.* at 22
108 *Id.*
109 *See generally* Kearney, *supra* note 51.

are often deprived of racially or ethnically sensitive counseling.[110]

Community colleges report more rapid increases over the last five years in the number of clients with problems related to sexual abuse, clinical depression, anxiety disorders, learning disabilities, eating disorders, medication issues, and crises requiring immediate response, than their 4-year counterparts.[111] Despite the clear need for services, community colleges are more likely than 4-year institutions to limit the number of counseling sessions allowed (approximately 41% of community colleges versus approximately 29% of 4-year institutions).[112] The majority of 2-year colleges are also more likely to cut off counseling sessions before students have fully resolved their issues, whereas 4-year institutions are more likely to see students for as long as it takes to resolve the issues that brought them to the counseling center.[113]

One of the reasons for the marked difference in the provision of mental health services at 2-year versus 4-year institutions is that counseling centers at community colleges do not focus exclusively on mental health counseling.[114] According to the 2014 Survey, 2-year colleges reported that on average approximately 15% of their counseling center time is devoted to career counseling and approximately 17% is devoted to academic counseling.[115] Four-year institutions reported dramatically lower numbers, perhaps because they are more likely to have career development centers that operate independently of their counseling centers.[116]

Four-year institutions are taking action to respond to the growing mental health crisis on college campuses across the country. Schools are improving and expanding their faculty and staff training on how to identify mental illness and refer students in a timely and appropriate manner.[117] All responding schools reported training their residential life staff, and more than 80% reported training their faculty as well (with larger universities training their faculty at higher rates).[118]

Thus, overall four-year institutions are responding to the mental

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110 *Id.* at 16.
111 *See* GALLAGHER, *supra* note 2, at 12-13.
112 *Id.* at 22.
113 *Id.*
114 *See id.* at 30-31.
115 *Id.* at 30-31.
116 *See id.* at 30.
117 ANXIETY DISORDER ASSOCIATION OF AMERICA, *supra* note 58, at 5.
118 *Id.*

health crisis on college campuses by expanding the mental health services offered. Community colleges, which frequently lack such services altogether, are not increasing services at the same rate.[119] According to the 2014 National Survey of College Counseling Directors, community colleges lost more counseling staff positions than they gained, while four-year institutions gained almost four times as many positions as they lost.[120] Approximately 4% of 2-year institutions report increasing staff in 2014, as opposed to approximately 28% of 4-year institutions.[121]

The 2014 National Survey also suggests that the services provided at two-year institutions might be of lower quality than those provided at four-year institutions.[122] According to the National Survey, none of the reporting community colleges evaluate counselors based on client outcome data.[123] Instead, community colleges primarily evaluate staff based on their job description and annual goals.[124] In contrast, approximately 16% of four-year institutions rely on client outcome data in assessing counseling staff.[125]

This next section looks more closely at the community college systems in the states of Virginia and California. It also looks at how a number of specific community colleges are taking action to expand and improve their mental health programs.

Part IV: Case Studies of Virginia and California

Virginia

Almost half a million students attend Virginia's colleges and universities and over one third of those students attend a two-year community college.[126] Virginia ranks sixth in the nation for degree attainment.[127] Nearly 36% of adults in Virginia between the age of 25 and 64

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119 GALLAGHER, *supra* note 2, at 22-26.

120 GALLAGHER, *supra* note 2, at 22.

121 *Id.* at 26.

122 *See id.*

123 *Id.* at 23.

124 *Id.* at 11.

125 *Id.*

126 BONNIE, *supra* note 62, at 9. Of the almost half a million students attending college in Virginia, about 45% attend one of the 15 four-year public colleges; 17% attend one of the 25 four-year private colleges, and 38% attend one of the 24 public two-year colleges (including the 23 community colleges).

127 *Assessment of Opportunities and Models for Adults to Complete the Baccalaureate*

have earned a bachelor's degree or higher.[128] But, as a recent study by the State Council of Higher Education for Virginia cautions, the relatively high statewide educational attainment rate for Virginia masks significant disparities related to geography and demographics.[129] Many rural and economically distressed urban areas have lower rates of educational attainment, and minority populations also have lower degree attainment rates.[130]

Many college students in Virginia attend two-year colleges, including a significantly higher percentage of African American and Hispanic students than attend four-year institutions in the state.[131] Unfortunately, some of the services offered at four-year institutions, particularly mental health services, are officially unavailable at Virginia's two-year institutions.[132] Even though mental health services are known to increase retention and graduation rate, they are less accessible for students enrolled at two-year colleges, who are statistically at the highest risk of not completing school.[133]

Community College System

The Virginia General Assembly established the Virginia Community College System (VCCS) in 1966.[134] The VCCS currently comprises 23 colleges spread across 40 campuses statewide.[135] According to the VCCS website, 60% of Virginia undergraduate students are enrolled in community colleges, and 56% of community college graduates are in transfer programs planning to pursue a bachelor's degree.[136] Virginia Community Colleges serve as a stepping stone for many Vir-

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Degree at Virginia Four-Year Institutions, STATE COUN. ON HIGHER ED. FOR VA. 1, 3 (2012), http://www.schev.edu/docs/default-source/Reports-and-Studies/2012/adultlearnerfactsheet.pdf?sfvrsn=4.

128 *Id.*

129 *Id.*

130 *Id.*

131 *Id.*

132 BONNIE, *supra* note 62, at 10.

133 *Id; see also The College Completion Challenge Fact Sheet*, AM. ASS'N OF CMTY. COLL., http://www.aacc.nche.edu/About/completionchallenge/Documents/Completion-Fact_Sheet.pdf (last visited Nov. 17, 2016) (noting 3 out of 10 community college students complete their education).

134 *About: Educating Virginia Since 1966*, VA. CMTY. COLL., http://www.vccs.edu/about/ (last visited Nov. 17, 2016).

135 *Find a Virginia Community College*, VA. CMTY. COLL., http://www.vccs.edu/about/where-we-are/college-locator/ (last visited Nov. 17, 2016).

136 *Impact: Research and Statistics for Virginia's Community Colleges*, VA. CMTY. COLL., http://www.vccs.edu/about/where-we-are/impact/ (last visited Nov. 17, 2016).

ginians seeking workforce training or seeking to attain a four year degree at one of the more than 25 colleges in Virginia that have a Guaranteed Admissions Agreement (GAA) with Virginia's Community Colleges.[137]

The community college student population in Virginia is growing, getting younger, and becoming increasingly diverse.[138] Between 1987 and 2006, total enrollment at Virginia's public two-year institutions grew by approximately 29%.[139] The percentage of undergraduate students enrolled at two-year institutions who were attending college for the first time grew by approximately 95% between 1992 and 2006, meaning that the community college demographic now comprises more traditional aged students.[140] The community college population in Virginia is also becoming more diverse. While total minority enrollment at Virginia's four year undergraduate, graduate, and first professional programs increased by 32% between 1992 and 2004, minority enrollment at two-year institutions increased by 66%, over twice as much.[141]

The VCCS prides itself on meeting the unmet educational needs of Virginians, and recently announced its strategic plan, called "Achieve 2015."[142] The plan outlines specific goals which fall under several categories, including student success, affordability, workforce, and fundraising.[143] Integral to this strategic plan is the VCCS's intention to increase the number of college graduates by 100,000 in the next 15 years.[144] Unfortunately, student mental health services are not mentioned in the strategic plan.

State of Mental Health and Provision of Mental Health Services

Students enrolled in colleges and universities in Virginia are experiencing the "mental health crisis" that has become increasingly

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137 *Id.*

138 *Enrollment Trends at Virginia's Public Colleges and Universities*, STATE COUNCIL OF HIGHER ED. FOR VA. 1, 4 (Sep. 2007), http://www.schev.edu/docs/default-source/Reports-and-Studies/2007/2007enrollmentreport.pdf?sfvrsn=4.

139 *Id.*

140 *Id.*

141 *Id.* at 7.

142 *Our Strategic Plan*, VA. CMTY. COLL., http://www.vccs.edu/about/where-we-are-going/ (last visited Nov. 19, 2016).

143 *Id.*

144 *Id.*

common at colleges and universities across the country.[145] Data from national and state sources suggests that at least 46,000 college students in the state are experiencing significant mental health problems and require mental health assistance.[146] At least 11 Virginia college students committed suicide and at least 86 more attempted suicide during the 2008-2009 year.[147]

Four-year colleges and universities in Virginia generally provide mental health counseling services to students—all of the 15 four-year public colleges provide such services to enrolled students and 22 of the 25 private colleges provide such services.[148] While most Virginia colleges meet minimum recommended counselor to student ratios, most counseling centers fail to provide psychiatric services.[149] Nonetheless, 60% of four-year private colleges and 25% of four-year public colleges in the state require students to have health insurance.[150] Therefore it is possible for many four-year colleges to refer students to off-campus providers when they are unable to meet the students' mental health needs at their own mental health center.[151]

Despite the fact that community college students are at no less risk of mental health concerns, community colleges in Virginia lag far behind four-year institutions in the state in terms of the provision of mental health services.[152] According to official state policy, Virginia's community colleges do not currently provide mental health services.[153] Additionally, community college students are less likely to be insured than students at four-year institutions, especially since none of the two-year colleges in the state require that students have health insurance.[154] Therefore, a higher percentage of community college students lack access to off-campus mental health services as well.

Actions and Strategic Initiatives

In the aftermath of tragedies such as the Virginia Tech Shooting

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145 *Id.*
146 BONNIE, *supra* note 62, at 9
147 *Id.*
148 *Id.*
149 *Id.*
150 *Id.* at 15.
151 BONNIE, *supra* note 62, at 15.
152 *Id.* at 30.
153 *Id.* at 10.
154 *Id.*

on April 16, 2007, educational institutions in Virginia, as well as the state and federal government, have been forced to reevaluate the policies and procedures that are in place relating to student mental health.[155] Recognizing that the provision of mental health services at many institutions of higher education in Virginia is inadequate, the state is taking action to improve and expand the services offered at both two-year and four-year institutions.[156]

Richard Bonnie, a law professor at the University of Virginia, is at the head of an effort to close the gap in mental health services for students enrolled at community colleges.[157] As Chairman of the Virginia College Mental Health Study, Bonnie collaborated with mental health officials across the state to study mental health programs at institutions of higher education in Virginia. Bonnie presented his research in the form of a report to the General Assembly of the Commonwealth of Virginia in 2011.[158] This Virginia College Mental Health Study is not only concerned with the provision of mental health services at the state's four-year institutions; rather, it specifically addresses the limited provision of mental health at community colleges, identifying this as one of the most important issues for Virginia to consider.[159] The task force makes a number of recommendations in its report, the first of which relates specifically to the provision of mental health services for community college students:

> The Commonwealth should embark on a sequential plan, as resources permit, to assure that every community college has the capacity to provide brief screening and referral services for students who appear in need of mental health intervention; to maintain fully staffed threat assessment teams; to conduct risk assessment screenings in cases that may pose a risk of harm to campus safety; and to coordinate with CSBs, law enforcement agencies and families to carry out emergency interventions and other types of crisis response when necessary.[160]

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155 *See id.*

156 *Id.*

157 *See id.*

158 The study was also published as a journal article in *Developments in Mental Health Law. See* Richard Bonnie, *College Mental Health Study Measures Student Access to Mental Health Services Four Years After Virginia Tech Tragedy*, 31 DEV. MENTAL HEALTH L. 1, *passim* (2011).

159 BONNIE, *supra* note 62, at 10.

160 *Id.* at 37.

This is not the only recommendation that has important implications for community colleges. The second recommendation emphasizes the importance of providing culturally sensitive counseling services, which is vital given the extremely diverse community college demographic.[161] The Virginia College Mental Health Study is significant because it is the only major work calling attention to the urgent mental health needs of community college students in the state of Virginia.

The Virginia College Mental Health Study suggests that Virginia is moving in the right direction, in terms of making sure that all of its college students received the mental health services that they need. The state still has a long way to go.

The next section looks at the California community college system.

California

The California state legislature adopted California's Master Plan for Higher Education in 1960, establishing the state's current tripartite system of higher education.[162] This system includes the California community colleges (CCC) system, the California State University (CSU) system, and the University of California (UC) system.[163] California's tripartite system of public higher education, which is over 50 years old, has been ranked by some as the best system of higher education in the world, although recent studies suggest that the state's Master Plan needs to be revitalized to reflect the changing needs of the population.[164] As of 2012, 34% of Californians age 25 or older had at least a bachelor's degree.[165]

Community College System

With more than 2.1 million students spread across 112 campuses, California has the highest rate of public attendance nationally among all community college systems and educates over 2 million people a

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[161] *Id.* at 38.

[162] HANS JOHNSON, HIGHER EDUCATION IN CALIFORNIA: NEW GOALS FOR THE MASTER PLAN, PUB. POLICY INST. OF CA. 1, 3 (2010), http://www.ppic.org/content/pubs/report/R_410HJR.pdf.

[163] *Id.*

[164] *Id.*

[165] *Adult Educational Attainement, 2012,* Public Policy Institute of California, http://www.ppic.org/main/keystat.asp?i=1264.

year.[166] In fact, one quarter of community college students nationwide attends a California community college.[167] And three out of every ten California residents between the ages of 18 and 24 attends a community college.[168] The California community college system attracts a diverse student body, with 53% of students hailing from diverse ethnic backgrounds.[169]

The California Community College System represents an excellent investment on the part of the state: for every $1 invested by the state in students who graduate from college, the state receives a return of $4.50.[170] Students who earn a degree from a community college have an easier time finding jobs and nearly double their earnings within three years of graduating.[171] The California Community College System is extremely cost-effective: the revenue required to support one full time student is just over $5,000 a year.[172]

Thus, California community colleges play a vital role in the state— providing education to minority students at higher rates than four-year institutions; providing essential workforce training[173]; preparing students to transfer to four-year institutions; educating students at all stages of their lives; and boosting California's economy.[174]

Mental Health Experience and Mental Health Services Available

California has invested significant resources in evaluating the mental health of its community college students, and studies show that community college students are experiencing a variety of mental health issues. Currently, 19% of community college students report experiencing psychological distress, with even higher rates reported among

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[166] CALIFORNIA COMMUNITY COLLEGE KEY FACTS, CA. CMTY. COLL. CHANCELLOR'S OFFICE 1, 5 (Jan. 16, 2015), http://californiacommunitycolleges.cccco.edu/Portals/0/DocDownloads/Articles/California_Community_Colleges_Key_Facts_Updated_1_16_15.pdf.

[167] *Id.*

[168] *Id.*

[169] *Id.* at 5.

[170] *Id.* at 3.

[171] *Id.*

[172] *Id.*

[173] California Community Colleges represent the largest provider of workforce training in the state and in the nation. Remarkably, California community colleges educate 70% of the state's nurses and 80% of the state firefighters, law enforcement personnel, and emergency medical technicians. *Id.*

[174] *Id.*

biracial students, students with disabilities, and lesbian, gay, bi-sexual, transgender and questioning students.[175] Community college students in California experience higher rates of impaired academic performance because of mental health issues than students at four-year institutions in the state.[176] This might be attributed to the fact that, despite experiencing similar levels of psychological distress, community college students are half as likely as their peers at four-year institutions to receive referrals for mental health services.[177]

In the Spring of 2013, the American College Health Association conducted a study looking at the general health of California community colleges students, including their mental health.[178] Almost a third of students reported being so depressed at some point in the last 12 months that it was difficult to function.[179] Almost half of students felt overwhelming anxiety or felt things were hopeless some time in the last 12 months.[180] Additionally, a small percentage of students reported that they had attempted suicide at some point in the previous year or intentionally cut, burned, bruised, or otherwise injured themselves.[181]

In 2013, The California Mental Health Services Authority (CalMHSA) conducted an extensive web-based survey of students and faculty/staff on the UC, CSU, and CCC campuses.[182] Many of the survey responses are broken down by type of school, which is useful in assessing the provision of mental health services specifically at California community colleges. According to the polling of community college faculty and staff, 51% agreed that their campus provided adequate services for unique student needs; 57% agreed that their campus provided effective support for depression, stress, and drug use; 54% agreed that their campus provided adequate mental health services; and

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[175] CALIFORNIA COMMUNITY COLLEGES STUDENT MENTAL HEALTH PROGRAM FINAL EVALUATION REPORT, PREVENTION RESEARCH CTR. i, iv (May 2015), http://www.cccstudentmentalhealth.org/docs/evaluation/CCCSMHP_PIRE_FinalEvalReport_May2015.pdf.

[176] *Id.*

[177] *Id.*

[178] AM. COLL. HEALTH ASS'N, CALIFORNIA COMMUNITY COLLEGES REFERENCES GROUP SUMMARY 1, *passim* (Spring 2013), http://www.cccstudentmentalhealth.org/docs/evaluation/ACHA-CCC-Ref-Group-Spring2013-Exec-Summary.pdf.

[179] *Id.* at 14.

[180] *Id.* at 13-14.

[181] *Id.*

[182] LISA SONTAG-PADILLA, ET AL., CALMHSA STUDENT MENTAL HEALTH CAMPUS-WIDE SURVEY: 2013 SUMMARY REPORT, CALMSHA 1, 1-8 (2013), http://calmhsa.org/wp-content/uploads/2014/06/CalMHSA-SMH-Campus-Wide-Survey-2013-Report-2.pdf.

56% agreed that their campus emphasized helping students with emotional, social, and behavioral needs.[183]

In contrast to the UC and CSU systems, which have mental health clinics on every campus, each California community college makes an individual decision regarding whether or not to have a mental health clinic on campus.[184] This might account for the fact that UC and CSU students access mental health services at approximately double the rates of CCC students.[185] Despite California's impressive strides in extending mental health services to community college students, the findings from this survey indicate an increased need for mental health supports at community colleges across the state.[186]

California's Actions and Strategic Initiatives

California is committed to responding to the mental health needs of community college students. There are a number of strategic initiatives underway in California designed to expand access to mental health services for community college students and to bolster the efficacy of campus mental health programs. This section considers several key initiatives, with a focus on the California Community College's Student Mental Health Program (CCC SMHP). The CCC SMHP is a partnership between the California Community Colleges Chancellor's Office (CCCCO) and the Foundation for Community Colleges (FCCC). It represents a statewide effort to implement prevention and early intervention strategies, which address the mental health needs of students at California community colleges.[187]

The CCC SMHP focuses its efforts primarily on faculty and staff training, peer-to-peer support, and suicide prevention.[188] The CCC SMHP has awarded 23 grants serving 30 community colleges across the state, with an emphasis on enhancing county and local community mental health partnerships.[189] As a part of these grants, schools have

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183 *Id.* at 4.

184 *Id.* at 6.

185 *Id.* at 5.

186 *Id.* at 5.

187 FOUND. FOR CA. CMTY COLL., THE CALIFORNIA COMMUNITY COLLEGES STUDENT MENTAL HEALTH PROGRAM (CCC SMHP) FREQUENTLY ASKED QUESTIONS 1, 4 (Mar. 11, 2014), http://extranet.cccco.edu/Portals/1/SSSP/MentalHealthServices/CCC_SMHP_FAQs_Update_4_March2013.pdf.

188 *Id.*

189 CCC SMHP, CALIFORNIA COMMUNITY COLLEGES STUDENT MENTAL HEALTH

been required to participate in a data collection effort, which has resulted in the largest set of community college health data ever collected nationally.[190] This data set provides participating colleges with vital data about mental health issues among community college students, which benefits the college system as a whole.[191]

The CCC SMHP posts "campus based profiles" on its website, which showcase the many community colleges that have used SMHP funding to develop thriving mental health programs. Each profile features a college campus and provides an overview of its mental health program, including program strategies, methodology, populations served, and collaborative partners.[192] For example, the grant profile for the College of San-Mateo shows that the college serves a diverse body of over 10,000 students, and that it has documented an alarming increase in the number of students experiencing serious mental health challenges, particularly among students under 18, student veterans, and lesbian, gay, bi-sexual, transgender, and questioning students.[193] The college of San Mateo seeks to change the campus climate, reduce stigma, and improve its ability to respond to potential violence.[194] San Mateo has developed its own student mental health project, called "CSM Cares," with the goals of increasing staff and faculty capacity to implement student behavioral interventions; improving threat assessment and communication systems; developing a peer-to-peer program; and finally, increasing collaboration with community partners.[195]

Other schools have used their grants to ameliorate different types of problems. For example, College of the Desert, which serves about 10,000 students on three campuses, lacked the ability to address the basic mental health needs of its students.[196] Therefore, it is using its campus based grant primarily to enhance general mental health ser-

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PROGRAM PARTNER SUMMARY OF EVALUATION FINDINGS 1, 2 (Apr. 30, 2014), http://www.cccstudentmentalhealth.org/docs/CalMHSA_Partner_Summary_Annual_Report_2014.pdf.

190 *Id.* at 3.

191 *Id.*

192 CCC SMHP, CAMPUS BASED GRANT PROFILES (2013), http://www.cccstudentmentalhealth.org/docs/CBG_Profiles.pdf.

193 CCC SMHP, COLLEGE OF SAN-MATEO: CAMPUS BASED GRANT PROFILE (2013), http://www.cccstudentmentalhealth.org/docs/CBG_Profiles.pdf.

194 *Id.*

195 *Id.*

196 CCC SMHP, COLLEGE OF THE DESERT: CAMPUS BASED GRANT PROFILES (2013), http://www.cccstudentmentalhealth.org/docs/CBG_Profiles.pdf.

vices.[197] Cuesta College has developed its own mental health program, "Creating Spaces," which promotes early prevention and early intervention by increasing awareness among faculty and staff.[198]

The CCC SMHP has made progress in bridging the gap between students and needed mental health services. CCC SMHP has even developed a centralized training and technology assistance program, which allows formerly isolated community colleges to communicate and pool mental health resources.[199] Almost one thousand students, faculty and staff have already participated in CCC SMHP trainings, presentations, events, and workshops.[200] An even higher number of individuals have completed the online suicide prevention trainings, which are recognized nationally for their excellence.[201] Additionally, as of 2014, 108 of the 112 community college campuses in the state have participated in training and technical assistance programs.[202]

Several other organizations in the state are committed to promoting awareness at California's community colleges. The Health Services Association of California Community Colleges (HSACCC), which is comprised of college student health professionals from all over the state, is known for conducting important research and studies on issues relating to mental health and college students.[203] The California Community College Mental Health and Wellness Association (MHWA) is an organization devoted to "(enhancing) student success, wellness, and retention by the support and promotion of quality mental health services programs throughout the 110 colleges of the California Community College System."[204] Some of the organization's activities include providing continuing education and training for mental health professionals, promoting communication and support among mental health and other health service professionals, establishing professional qualifications and program standards within the college setting, and dissem-

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[197] *Id.*

[198] *Id.*

[199] *Id.* at 3.

[200] *Id.* at 1.

[201] *Id.*

[202] *Id.*

[203] CSSO'S OF THE CALIFORNIA COMMUNITY COLLEGES, *Examining Mental Health Data in California Community Colleges*, http://www.ohlone.edu/org/healthcenter/docs/20081000ijournal-examiningmentalhealthinccc.pdf.

[204] MHWA, CALIFORNIA COMMUNITY COLLEGE MENTAL HEALTH AND WELLNESS ASSOCIATION, http://www.mhwa.org/uploads/6/8/3/9/6839277/mhwa_factsheet_021113.pdf (last visited Nov. 27, 2016).

inating information relevant to college mental health.[205]

California's commitment to the mental health needs of community college students sets it apart from most other states. This commitment is prudent given the large percentage of California students enrolled in community colleges and the vital role they play in the state's social and economic functioning.

This next section discusses the future provision of mental health services at community colleges across the country.

Part V: Looking Forward

There is a great disparity in the provision of mental health services at community colleges as compared to four-year colleges and universities. Given the importance of such services, it is imperative that two-year institutions begin to view the provision of mental health services as a priority. This section of the note draws upon several mental health action planning guides, including a comprehensive publication by the Jed Foundation,[206] as well as surveys and case studies, to identify best practices for instituting mental health programs at community colleges. This section is not meant as a comprehensive guide. It is meant only to start a conversation about identifying institutional needs, developing a model approach, and implementing a plan.

A. Identifying What Your Institution Needs

The first step in developing an effective mental health program involves evaluating the state of mental health on campus and identifying specific campus needs.[207] A successful mental health program must be "comprehensive, strategic, and well-planned."[208] Institutions should engage in a thorough risk assessment that considers objective data about the issues students are experiencing and the prevalence and the risks associated with these issues.[209] This risk assessment might involve a formal campus survey or might involve something less formal,

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[205] *Id.*

[206] *About Us*, THE JED FOUNDATION, https://www.jedfoundation.org/who-we-are/ (last visited Nov. 28, 2016).

[207] THE JED FOUNDATION, A GUIDE TO CAMPUS MENTAL HEALTH ACTION PLANNING, CAMPUS MHAP MENTAL HEALTH ACTION PLANNING 1, 8 (2011), http://www.sprc.org/sites/default/files/resource-program/CampusMHAP_Web%20final.pdf.

[208] *Id.*

[209] *Id.* at 9.

such as a town hall meeting or one-on-one interviews with faculty, staff, and students.[210] It might also be based on existing data, such as surveys conducted as part of the National College Health Assessment (NCHA).[211]

While the availability of basic mental health services is essential, it might not be enough to effectively address mental health issues on some campuses. Many colleges are taking a public health approach to mental health issues by addressing both prevention and treatment.[212] The campus based grant profiles discussed in the case study of California, provide an example of the ways in which schools might evaluate the unique needs of their student population.[213] For example, several schools identified at risk populations, including minority students, and customized their mental health program to target these populations.[214] The campus based grant profiles also demonstrate the ways in which community colleges might collaborate with campus-based and community partners to meet the specific needs of at-risk populations. For example, Butte College, which consists of three campuses in north-central California, has fostered partnerships with the Butte County Department of Behavioral Health, the Glenn County Health Services Agency, California State University at Chico, and North Valley Catholic Social Services, among others.[215]

B. Developing a Mental Health Plan

Guiding Principles

Developing an official school policy on mental health is essential to showing a school's commitment to taking mental health seriously. Every institution's policy will look different, and each should reflect student needs and campus concerns specific to that institution. Putting together a mental health policy represents an invaluable opportunity for an institution to voice its commitment not only to mental health, but also to vulnerable groups on campus identified during the risk assessment.

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210 *Id.*
211 *Id.*
212 *Id.*
213 *See* CCC SMHP, CAMPUS BASED GRANT PROFILES, *supra* note 192.
214 *Id.*
215 *Id.*

A variety of sample mental health policies are accessible online, often directly through school websites. The Bazelon Center for Mental Health Law, for example, provides a model policy for colleges and universities interested in implementing an effective mental health program.[216] While model policies are designed to serve as only a general guide, there are a few key components that schools should address in some capacity. First, a school's mental health policy should begin by setting a general intention and/or delineating guiding principles, which might include encouraging students to seek the mental health treatment they need without worrying about jeopardizing their academic career and making services widely available and easily accessible, etc.[217]

Next, a mental health policy should include specific provisions explaining the availability of counseling and mental health services, including the types of services offered, any relevant fees, and any additional supports that students might have available to them.[218] The college should also set forth voluntary and involuntary leave policies, so that both students and administration are aware of how such situations will be handled in advance.[219] Students must be able to understand why they are being asked to take an involuntary leave. Confidentiality is another important issue that should be addressed in a school's mental health policy. Students might be more apt to seek services if they are satisfied that their information will remain confidential.[220] This is by no means an exhaustive list, since each school's mental health policy, like its student population and campus dynamic, will be different.

Building Support

Launching a new mental health program or improving an existing program requires the support of the campus community, including administrators, faculty, support staff, and students, as well as the local community.[221] Individuals from all of these groups play a critical role in building momentum and infrastructure, and their commitment is vi-

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216 J. DAVID L. BAZELON CTR. FOR MENTAL HEALTH L., SUPPORTING STUDENTS: A MODEL POLICY FOR COLLEGES AND UNIVERSITIES 1, 3 (2007), http://www.bazelon.org/pdf/supportingstudents.pdf.

217 *Id.*

218 *Id.*

219 *Id.*

220 *Id.*

221 THE JED FOUNDATION, A GUIDE TO CAMPUS MENTAL HEALTH ACTION PLANNING, *supra* note 207, at 4.

tal to the long-term success of any mental health program.[222] It is especially important to secure the support of key administrators early on.[223] Specifically, experts in campus mental health planning emphasize that in order for an institution's mental health program to be effective, college presidents and senior officials must "establish suicide prevention and mental health promotion as a priority and allocate funding to develop and sustain these initiatives."[224]

Building support might take a variety of forms, such as appointing specific employees or groups charged with promoting mental health awareness. For example, a college might consider appointing or hiring a staff member charged solely with coordinating and developing programs, policies, and services relating to mental health on campus.[225] On larger campuses, where multiple senior administrators support the development of a strong mental health program, it may be possible to develop a mental health task force to study campus problems, make recommendations, and provide important educational information to the campus community.[226] It could also be useful to engage health professionals on campus, such as the director of health education.[227] The community represents another important ally. The campus grant profiles discussed in the California case study reflect the variety of potential community partners, and the ways in which community colleges can collaborate with them.[228] Thus, local communities constitute a rich resource.

Implementing a strong mental health program not only requires the support of the campus community, but it also requires adequate funding. Securing funding might be easier if institutions have done a good job of building support from administrators, students, community members, and other key stakeholders, as well as state and local government.[229] Community colleges have a number of financial resources that they can take advantage of, including reallocating the resources that they already have or imposing additional students fees to fund

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222 *Id.*
223 *Id.*
224 *Id.*
225 *Id.*
226 *Id.*
227 *Id.* at 5.
228 *See* CCC SMHP, CAMPUS BASED GRANT PROFILES, *supra* note 192.
229 THE JED FOUNDATION, A GUIDE TO CAMPUS MENTAL HEALTH ACTION PLANNING, *supra* note 207, at 4.

these services.

Community colleges might seek financial assistance from their local communities or from the state. Community colleges in California, for example, have successfully sought tremendous support from both state and local sources.[230] Schools might also petition their state representatives for legislation promoting mental health services and allocating funds for the development of mental health programs.

Community colleges might also consider seeking out federal grants allocated for mental health activities. The Substance Abuse and Mental Health Services Administration (SAMHSA), a federal agency, has awarded generous grants in the past under the Garrett Lee Smith Memorial programs to support mental health programs at colleges.[231]

C. Implementing the Model

Once a school has developed a model policy and has obtained adequate community support and funding, it can move forward with implementing that model. Colleges might consider developing an action plan, or a detailed work plan, that lists all of the actions or changes that will occur, who will carry out the actions, the dates by which things occur, and what resources (including money and staff) must be allocated.[232] This plan might be made public, or circulated among those involved in the campus community.

One of the first steps on the action plan will likely involve training and/or hiring. This process will look very different depending on an institution's current composition. For example, it might involve hiring a number of individuals, or merely training current employees. It is important that all faculty and staff, not just counseling center staff, are made aware of mental health issues on campus and trained to identify problems and properly refer students to services.[233] As previously dis-

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[230] *See* discussion *infra*, "California's Actions and Strategic Initiatives."

[231] SAMHSA, *Campus Suicide Prevention Grant* (2014), http://www.samhsa.gov/grants/grant-announcements/sm-14-014; Rebecca Farley, *House Passes 2014 Budget Deal; Includes Funding Bump for Mental Health,* NAT'L COUNCIL FOR BEHAVIORAL HEALTH (Jan. 16, 2014), https://www.thenationalcouncil.org/capitol-connector/2014/01/house-passes-2014-budget-deal-includes-funding-bump-mental-health/. Announcing that $48 million was earmarked for Garrett Lee Smith Memorial programs, which provides funds for mental health and suicide prevention programs at schools across the country.

[232] THE JED FOUNDATION, A GUIDE TO CAMPUS MENTAL HEALTH ACTION PLANNING, *supra* note 207, at 15.

[233] *See id.* at 18, illustrating how an institution might involve non-clinical staff in its efforts to assist distressed students.

cussed it is also important that mental health center staff members are trained to provide ethnically and culturally sensitive services.[234] There are professional materials publically available for institutions that are unfamiliar in this area.[235]

Once an organization has completed the training/hiring process and a program is in place, it is imperative to get the word out to students. This can occur in a number of ways. According to the a 2012 study by the National Alliance for Mental Health (NAMI), most students learn about mental health services by visiting an institution's website.[236] Another effective method might involve incorporating mental health awareness and information related to on campus services into student orientation or other events attended by all students.[237]

After establishing basic mental health services and training across campus, colleges might consider expanding their activities: implementing campus wide educational programs; focusing on prevention and treatment; and developing "campus teams".[238] Additionally, institutions should make efforts to evaluate their programs to see if they are achieving their goals. Experts in campus mental health planning suggest that this information can be used for multiple purposes: to improve the program; to consider ways to expand the program or keep it going; and to communicate successes to senior administrators, key stakeholders, and possibly funding partners.[239]

D. Looking to the Future

The goal of this note is to promote parity in mental health services for community college students. Community colleges play an indispensable role in educating about half of all undergraduate students, yet many of these students lack access to basic mental health services.[240] As the role of community colleges continues to expand, it is imperative that these institutions develop adequate mental health programs. Following in the footsteps of community colleges in California, communi-

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234 *See infra*, Part I, Section B.

235 GALLAGHER, *supra* note 2, at 5.

236 NAMI, COLLEGE STUDENTS SPEAK, *supra* note 3, at 11.

237 *Id.* at 10.

238 *See* THE JED FOUNDATION, BALANCING SAFETY AND SUPPORT ON CAMPUS: A GUIDE FOR CAMPUS TEAMS 36, http://hemha.org/campus_teams_guide.pdf.

239 *See* THE JED FOUNDATION, A GUIDE TO CAMPUS MENTAL HEALTH ACTION PLANNING, *supra* note 207, at 4.

240 *See supra*, Part II.

ty colleges across the country can develop effective mental health programs and dramatically improve the mental health and academic success of their students, as well as the general welfare of their communities.

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